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FAMILY SYSTEM AND COGNITIVE BEHAVIOURAL THERAPIES IN THE MANAGEMENT OF MARITAL DYSFUNCTION AMONG MARRIED INDIVIDUALS IN ANAMBRA STATE, NIGERIA

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ABSTRACT: *Marital dysfunction (MD) occurs when there are unresolved conflicts between married individuals steadily over time. The rates of MD have increased in Nigeria, particularly in Anambra State (AS). Previous studies focused more on causes of MD among married individuals with little attention to interventions, such as family system therapy (FST) and cognitive behavioural therapy (CBT), to manage the problem. This study was carried out to determine the effects of FST and CBT on the management of MD among married individuals in AS. The moderating effects of self-esteem (SE) and socio-economic status (SES) were also investigated. The study was anchored to Bandura's Social Cognitive Theory, while the pretest-posttest control group quasi experimental design with a 3 × 3 × 3 factorial matrix was adopted. The multi-stage sampling procedure was used. The 3 senatorial districts (South, North and Central) in AS were enumerated. The simple random sampling technique was used to select one Local Government Area (LGA) each from the 3 senatorial districts and a town from the selected LGA. Three (3) town halls (one per LGA) where people gather were selected. Three hundred and eighty-four (384) MDs who were willing to participate were screened with Marital Dysfunction scale (MDS) (α =0.78), and 89 who scored 30 points and above on MDS were selected. The town halls were randomly assigned into FST (30), CBT (30), and control (29) groups. The instruments used were MD Test (α =0.81), SE (α =0.80) and SES (α =0.81) scales. The treatment and intervention guides lasted 8 weeks. The data were analysed using Analysis of covariance and Bonferroni pair-wise test at 0.05 level of significance. The participants' age was 28.0±2.1 years, and 65.0% were female. There was a significant main effect of treatment on MD ($F_{(2;61)}$ = 13.194, partial η^2 =.302). The participants in the FST group had the lowest mean score (31.10) on MD, followed by those in the CBT (31.56) and control (40.23) groups. This implies that participants in the FST group benefit more than other groups. There was a significant main effect of SE on married individuals' MD ($F_{(2;61)}$ = 3.42, partial η^2 = 0.10). The participants with high SE ($\bar{x}$ = 35.82) had a better reduction on MD than their counterparts with moderate ($\bar{x}$ = 35.26) and low SE ($\bar{x}$ = 31.81). There was no significant main effect of SES on MD. There was no significant interaction effect of treatment and SE on MD. There was no significant interaction effect of treatment and SES on MD. There was a significant interaction effect of SE and SES on MD ($F_{(4,61)}$ = 3.563, η_p^2 = .189) in favour of the participants with high SE. The three-way interaction effects of treatment, SE and SES were not significant. FST and CBT were effective in the management of MD among married individuals in AS, Nigeria, although the former was more effective. Therapies should adopt these interventions to reduce marital dysfunction.*

KEYWORDS: Family System Therapy, Cognitive Behavioural Therapy, Marital Dysfunction, Married Individuals in Anambra State.

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INTRODUCTION

The institution of marriage is universal, including all racial, ethnic, and religious groupings. Marriage is a consensual and legal lifelong union of a man and a woman. An exchange of possessions, rights, privileges, responsibilities, and statuses occurs in a marriage contract. However, since marriage is established via mutual consent and vows made by the partners, it is a covenant that goes beyond a formal agreement. Marriage commitment is therefore predicated on endurance, "till death do us part." Both the man and woman making the vows and the promise to be dedicated to each other must be emotionally stable, physically healthy, and mentally balanced at the same time. Put differently, they have to be psychologically vigilant to ensure that no one is tricked or pressured into making a commitment (Ani, 2009). There are several advantages to marriage that have a positive impact on one's life. The social structure is designed to provide married people with a happy existence and companionship (Bradbury, Fincham & Beach, 2010). Marriage offers financial security and the opportunity to have a sharing partner for emotions and experiences. Research has demonstrated that married people live longer, lead healthier lives, have fulfilling sexual relationships, and have greater wealth and financial assets (Waite & Galapher, 2016; Odebunmi, 2007). Married couples also tend to have children who perform better in two-parent households (Ezeani & Sabboh, 2021). According to Ojukwu (2013), stable marriages result in stable children and families, which in turn create a stable society.

The term "marital dysfunction" describes a personal perception of marriage that is characterized by destructive dispute resolution abilities, low levels of caring behaviors between partners, and deficiencies in commitment to the union. The prevalence of marital dysfunction changes throughout time and across cultural boundaries. According to Animasahaun (2014), there are a variety of variables that might lead to a marriage breaking down, and they vary greatly depending on the cultural and geographic context. Serkalem (2016) opined that in Ethiopia, women start arguments when they encounter adultery, extravagance, control over their own activities, physical abuse, and other issues in their marriages. It was noted in the data disclosed by Udobang (2018) that a number of married people had been victims of physical abuse, including spousal rape, beatings, and murder at the hands of their partners. There is much evidence in the modern day married people who are unhappy in their marriages and often think about taking their own lives as a way out. Marital dysfunction unsettles married people, shatters their happiness, and mostly affects women. It is one of the least acknowledged violations of human rights worldwide. It follows that marital dysfunction leads to unhappiness and discontent. It is also a serious societal issue that depletes married people's energy, jeopardizes their physical well-being, and undermines their sense of self-worth. People who go through the process of ending a marriage encounter difficult circumstances that negatively impact their mental health. Research has shown that, in comparison to happy married individuals, those who are experiencing conflict suffer from low psychological well-being, low self-esteem, low levels of happiness, psychological discomfort, and poor physical health (Ibeh, Obidoa & Okere, 2013). The method in which married people communicate at home, the existence of children, the influence of in-laws, the nature of the marriage bond, the gratification of sexual wants, and variations in employment are some of the elements that mostly lead to marital dysfunction.

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Asuzu and Ndukwe (2019) maintained that communication is the cornerstone of every successful marriage. Adequate communication enables married people to express their expectations for their marriage, including their financial situation and personal preferences, even before they tie the knot. It was emphasized that many married people do believe that their expectations for their marriage must be fulfilled when they tie the knot. However, when these expectations are not realized, dysfunction sets in. It is evident that couples experiencing dysfunction often struggle to communicate with one another (Akuezuilo & Nwanna, 2021). The effects of marital dysfunction are profound and enduring in the lives of men and women alike. It is the reason behind significant life changes that may lead to a great deal of stress for those affected and ultimately result in divorce (Obi & Ozumba, 2007). There can never be growth or calm in a household when there is constant upheaval, no peace, and marital disputes, and this may have an impact on the psychological health of the married people. Research has shown that immune system performance is negatively correlated with marital problems in both men and women (Ofole, 2015). Persistent marital dysfunction may lead to shattered households, which in turn encourages criminal activity and the emergence of young delinquents into society. Children from dysfunctional households also face scholastic setbacks and sometimes become dropouts due to their inability to handle home conflict and academic difficulties. The alarmingly high percentage of marital dysfunction in Nigeria has caused many young people to shy away from marriage. According to research, sixty-three percent of Nigerian marriages end in divorce, with newlyweds accounting for the majority of these cases (Afu & Nteh, 2020).

Since every family has a unique set of conflicting circumstances, there are many different types of marital dysfunction. After all, no two marriages are alike, and unusual marriages typically end in a unique way for a variety of reasons. Certain unions are harmonious and mostly devoid of issues. However, research has shown that marital dysfunction exists and does occur in the majority of relationships, overwhelming many others with crises (Tolorunleke, 2014). From the premarital period to the wedding day and the events that follow as the marriage develops, marital dysfunction may occur (Akinade, 2015). According to the aforementioned assertion, in order to lessen marital dysfunction, these two therapy interventions—family system and cognitive behavioural therapies—must be used. This is why the research was chosen to investigate the impact of cognitive behavioural therapy and the family structure on the management of marital dysfunction among married people residing in Anambra State, Nigeria.

Murray Bowen created the family system therapy (FST) in the latter half of the 1960s. This kind of psychotherapy assists people in resolving their concerns within the framework of their families, which is often the starting point for many difficulties. The main emphasis of family systems therapy is on the behavioural exchanges that occur throughout every family member's encounter. According to the treatment, family contact patterns initiate, support, and sustain both problematic and non-problematic behaviour in married people. The goal of non-pathology-oriented family system treatment is to locate and restore behavioural interactions between married people. According to FST, one of the main objectives of the treatment is to disrupt interactional patterns that support and maintain problematic behaviour so that alternative, non-problematic behaviours might emerge (Bowen, 1978; Jackson, 2005). Family systems theory also emphasized the critical relevance of context(s) to assign meaning to behaviour. FST has been used in certain Nigerian research to address marital issues. Okusun (2015), for example, looked at the impact of family system therapy on marital dysfunction in Kaduna households and found that the therapy was successful. Additionally, Oyafunke, Falola,

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and Salau (2014) looked at how family system therapy affected marital instability in the city of Abeokuta and discovered that it had a major impact. In contrast to individual, psychodynamic, genetic, or biophysiological theories that concentrate on processes assumed to be occurring inside the individual as motivating behaviour, the interrelated constructs of FST collectively reveal the critical relevance of interactional dynamics to understanding human behaviour (Snyder, Wills & Grady-Fletcher, 2011).

However, with a series of goal-oriented, specific, and methodical procedures that may come from marriage, Cognitive Behavioural Therapy (CBT) is a psychotherapy technique that tackles dysfunctional emotions, maladaptive behaviours, cognitive processes, and contents (Corey, Corey & Callanan, 2012). It is "problem-focused" (focused on particular issues) and "action-oriented" that a therapist works with to help a client choose certain tactics to help solve marital issues (Beck, 2016). This treatment has been utilized to address a variety of problems, including behavioural issues, marital instability, and dysfunction. The majority of the therapists who treat patients for anxiety and depression combine behavioural and cognitive therapy (Sanders, Hill, Hill & Elliott, 2014). This method admits that certain behaviours may not be within your control even with reasoned reasoning. More empirical research has been conducted on this psychotherapy model than any other, since it integrates cognitive and behavioural concepts and techniques into either a short-term or long-term treatment plan (Corey, 2013). CBT dates back to the 1950s, when researchers like Ivan Pavlov, John Watson, and Burrhus Frederic Skinner developed methods for changing problematic and undesirable learned behaviours with more socially acceptable positive ones. These methods include the use of reinforcers and consequences (Sharf, 2012). At the start of treatment, both parties have a better knowledge of the psychological processes that arise over time between two persons. As a behavioural therapy, CBT was created using the fundamental ideas of learning and conditioning.

CBT significantly replaces the negative schema about oneself, the world, and the future. It effectively treats depressed individuals as well as a number of psychiatric and marital issues, including marital dysfunction. Beck (2014) agreed that CBT is “problem-focused and action-oriented”; the therapist can affect the client's behaviour by helping him or her deal with difficult marital issues like marital dysfunction and eventually cause the abnormal behaviour to stop. In Awka, Nigeria, a research by Umeaku, Obi, and Anolue (2020) examined the impact of cognitive behavioural therapy (CBT) on marital instability in married persons and found that the intervention was successful in lowering marital instability. Hence, the study investigated the interaction effects of self-esteem and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria, while also looking at the effects of intervention strategies like FST and CBT on marital dysfunction among married individuals in that state. However, the moderating factors in the research were socioeconomic status and self-esteem. This is because socioeconomic status and self-esteem may play significant roles in marital problems.

Anderson and Polmhausen (2009) remarked that self-esteem is a married person's subjective evaluation of their own value and abilities. It is believed that having a high sense of self-worth is essential to both happiness and productivity. To successfully solve their issues, feel better about whatever decisions they make, and accomplish their own objectives, people desire and require good self-esteem. According to Mruk (2006), young people's self-esteem has drawn a lot of attention from both academic and popular sectors. The question of whether having a strong sense of self-worth is necessary, unimportant, or even harmful to one's wellness has

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been extensively studied and is still hotly debated (Brown, 2010). According to studies, married people with low self-esteem often experience marital issues, which may result in domestic abuse and other issues including marital dysfunction (Gullete & Lyon, 2006). Self-esteem has been linked to a wide range of outcomes, including marital dysfunction, since some studies that have been on this have regarded it as a global construct (Minev, Petrova, Mineva, Petkova & Strebkova, 2018). Low self-esteem has been linked to depression, suicidal thoughts, poor physical and mental health, decreased prospects for economic success, and higher levels of marital dysfunction, according to research (McGee & Williams, 2010; Cheng & Furnham, 2012). On the other hand, high self-esteem has been linked to happiness, acting as a buffer against negative feedback, assisting in the prevention of depressive symptoms, and lowering the rate of marital dysfunction among married people (Brown, 2010; Cheng & Furnham, 2012).

Socioeconomic status is another moderating element that was included in this research. The total monthly income of married persons depending on their place of residence, kind of employment, and level of education is referred to as their socioeconomic status. Stated differently, socioeconomic status is a notion that clarifies a person's place in society. Socioeconomic status (SES) includes not just money but also financial stability, level of education, and unique views of social class and rank. In relation to married people's social class status, Sorokowsi, Randall, Groyecka and Frackowiak (2017) define the socioeconomic status as an overall term that incorporates both resource-based and prestige-based indicators. According to research, family economics and educational characteristics are key indicators of socioeconomic status that have a significant impact on a family's health and well-being and may ultimately cause marital discord (Power, Hypponen, & Smith, 2005). Evans (2004) and Hudson (2005) hypothesized that the scarcity of resources and the unequal distribution of wealth and/or resources in a society, where married people find themselves acting as referees, have the potential to increase the psychological effects of living in lower socioeconomic groups, as this may lead to domestic violence, divorce, and other problems.

Asikhia (2010) observed that a married person's socioeconomic situation has a significant impact on the dysfunction of their marriage. According to Ushie, Emeka, Ononga and Owolabi (2012), family size, composition, socioeconomic level, and educational attainment all have a significant impact on social integration and married people's marital dysfunction. According to Ebenuwa-Okoh (2010), it might have an impact on married people's marriages if their financial circumstances are inadequate. Furthermore, Ebenuwa-Okoh (2010) maintained that if a spouse's financial requirements are sufficiently satisfied, there may be a decrease in marital abuse. Socioeconomic status related disagreement may lead to marital problems. Stress related to money is a frequent cause of argument. The kind and quantity of care that married people believe in may differ (McBride & Mills, 2010). It is noteworthy that most research works substantiating the adverse influence of socioeconomic status on marital happiness have used participant samples from individualist cultures, namely the United States and Canada. The result that socioeconomic position lowers marital dysfunction is significantly limited (Angelica, Lisbeth, Vanesa & Mariana, 2007; Schumn, Webb & Bollman, 2012). Extensive research conducted outside of Nigeria examined the impact of cognitive behavioural therapy and the family structure on the escalation of marital dysfunction. Because of this, Anambra State, Nigeria has to use intervention measures to reduce marital dysfunction, which makes the current research unique. Furthermore, the socioeconomic status and self-esteem that were chosen as moderating factors were mostly used in research that had little or nothing to do with marital problems. To close the gaps in the earlier research and contribute more to the body of

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current knowledge, the current study looked at the effects of the family system and cognitive behavioural therapy on the reduction of marital dysfunction among married individuals in Anambra State, Nigeria.

Hypotheses

The following seven hypotheses stated in the null form were formulated to guide the study at 0.05 level of significance:

$H0_1$: There is no significant main effect of treatment on marital dysfunction among married individuals in Anambra State, Nigeria.

$H0_2$: There is no significant main effect of self-esteem on marital dysfunction among married individuals in Anambra State, Nigeria.

$H0_3$: There is no significant main effect of socio-economic status on marital dysfunction among married individuals in Anambra State, Nigeria.

$H0_4$: There is no significant interaction effect of treatment and self-esteem on marital dysfunction among married individuals in Anambra State, Nigeria.

$H0_5$: There is no significant interaction effect of treatment and socio-economic status on marital dysfunction among married individuals in Anambra State, Nigeria.

$H0_6$: There is no significant interaction effect of self-esteem and socio-economic status on marital dysfunction among married individuals in Anambra State, Nigeria.

$H0_7$: There is no significant interaction effect of treatment, self-esteem, and socio-economic status on marital dysfunction among married individual in Anambra State, Nigeria.

METHODOLOGY

The study adopted pretest-posttest, control group quasi-experimental design with a 3 x 3 x 3 factorial matrix. In essence, the row consists of family system therapy and cognitive behavioural therapy, and the control. The population for the study comprised all married individuals with marital dysfunction and who are not more than 10 years in marriage within the three (3) senatorial districts (Anambra North, Anambra South and Anambra Central) in Anambra State, Nigeria, as recognised by the Nigerian national constitution.

A total of eighty-nine (89) married individuals in Anambra State, Nigeria was considered as the sample in the study. The sample was selected through multi-stage sampling procedure, which was done in five stages. The first stage was the total enumeration of all married individuals within the three senatorial districts of Anambra State, Nigeria. At the second stage, simple random sampling technique was adopted in selecting one local government each from the three senatorial districts in Anambra State. At the third stage, a simple random sampling technique was used in selecting one town from each of the local government selected from the senatorial districts, while at the fourth stage, convenient sampling techniques was adopted in selecting location, such as, kindred(s) hall, school hall, Church hall or town hall. At the final stage, purposive sampling techniques was adopted in selecting participants (married

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individuals) for the study, which was distributed into experimental groups and control group. Out of the 89 respondents, 65.2% of them were females, while 34.8% of them were males. The majority (64%) were within the age of 31 and 40 years, 25.8% belonged to the age group of 20 to 30 years, 9% were 41 years of age and above, while 1.1% were below 20 years of age.

The instrument used in the study was the marital dysfunction scale developed by Synder, Whisman and Beach (2010) and used to screen the participants in collaboration with the inclusion criteria stated in the study. Marital dysfunction scale is a 15-item inventory. Two sample items include: "I get pretty discouraged about our marriage sometimes" and "My partner often fails to understand my point of view on things." Each item was rated on a 4-point scale (1 = strongly disagree to 4 = strongly agree). The internal consistency reliability coefficient of the scale according to the authors was .87. The marital dysfunctional index scale was developed by Sobolewski (2007). It was designed to measure how often married individuals disagree and/or argue on issues. It contains twenty (20) items, and each item was rated using a 5-point Likert scale. The developer reported reliability of 0.81. Self-esteem scale was developed by Rosenberg (1965). This instrument was used to measure an individual's value or worth. This section consists of fifteen (15) items with a response format ranging from Strongly Agree = 5 to Strongly Disagree = 1. It has Cronbach alpha of .80. The instrument was adapted for the study. Socioeconomic status was measured using the Parents' Socio-Economic Status (PSES) developed by Salami (2000). The test-retest reliability of the scale when administered among 100 secondary school students in Ibadan, Oyo state, Nigeria was 0.73 with an interval of three weeks.

At the pre-session, the activities included the screening, recruitment and assigning of participants to the two experimental and control group. Advertisement was made to request for participants in the selected kindreds. A preliminary meeting was organised to familiarise with the interested participants and to solicit their willingness to participate in the study. At the pre-test stage, a questionnaire, comprising Socioeconomic Status Scale (SES) and Self-Esteem Scale and Marital Dysfunction Index Scale (MDIS), was administered to the participants. Participants in the two experimental groups only were exposed to eight sessions of treatment (Family System therapy and Cognitive Behavioural Therapy). Simple percentage and Analysis of Covariance (ANCOVA) were the major statistical tools that were employed in this study. Simple percentage was used to analyse the demographic characteristics of the respondents while ANCOVA was used to establish initial differences between the participants in the experimental and control groups. Also, Bonferroni Post-hoc analysis was used to determine the directions of the effective group among the three groups that were used in the study.

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RESULTS AND DISCUSSION

Hypotheses Testing

H0₁: There is no significant main effect of treatment on marital dysfunction among married individuals in Anambra State, Nigeria.

Table 1: ANCOVA Summary Showing the Main and Interaction Effect of Treatment, Self-Esteem and

Socioeconomic Status on Marital Dysfunction

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	2570.503[a]	27	95.204	3.304	.000	.594
Intercept	1432.066	1	1432.066	49.698	.000	.449
Pretest	408.112	1	408.112	14.163	.000	.188
Treatment	760.381	2	380.190	13.194	.000	.302
Self-esteem	197.114	2	98.557	3.420	.039	.101
Socioeconomic Status	77.547	2	38.774	1.346	.268	.042
Treatment * Self-esteem	234.712	4	58.678	2.036	.100	.118
Treatment * Socioeconomic Status	40.967	4	10.242	.355	.839	.023
Self-esteem * Socioeconomic Status	410.666	4	102.667	3.563	.011	.189
Treatment * Self-esteem * Socioeconomic Status	319.290	8	39.911	1.385	.221	.154
Error	1757.722	61	28.815			
Total	110364.000	89				
Corrected Total	4328.225	88				

a. R Squared = .594 (Adjusted R Squared = .414)

Table 1 reveals that there is a significant main effect of treatment on marital dysfunction among married individuals in Anambra State, Nigeria: $F_{(2;61)} = 13.194$, $p < 0.05$, partial eta-squared ($\eta^2 = .302$). Hence, the null hypothesis is not accepted. Therefore, the treatment used had a significant effect on marital dysfunction. This implies that there was a significant difference in marital dysfunction of participants based on their treatment groups. The size of effect shows

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that the treatment group explained (30.2%) (η_p^2 = .302) variance in marital dysfunction. To further show the margin of differences observed between the treatment groups and the control group, the pair-wise comparison using Bonferroni was carried out and the result is shown in Table 2.

Table 2: Bonferroni Pair-wise Comparison Showing the Significant Differences Among the Treatment Groups and the Control Group

(I) Treatment	(J) Treatment	Mean Difference (I-J)	Std. Error	Sig.[b]
FST (Mean = 31.104)	CBT	-.456	1.685	1.000
	Control	-9.127*	1.929	.000
CBT (Mean = 31.560)	FST	.456	1.685	1.000
	Control	-8.671*	1.927	.000
Control (Mean = 40.231)	FST	9.127*	1.929	.000
	CBT	8.671*	1.927	.000

Table 2 shows that after controlling for the effect of pre-test scores on marital dysfunction, experimental group I (FST, mean = 31.104) had the lowest mean score on marital dysfunction, followed by the experimental group II (CBT, mean = 31.560) and control group (mean = 40.231). By implication, although not significant, this implies that FST is more potent in reducing marital dysfunction than CBT.

$H0_2$: There is no significant main effect of self-esteem on marital dysfunction among married individuals in Anambra State, Nigeria.

Table 1 shows that there was a significant main effect of self-esteem on marital dysfunction among married individuals in Anambra State, Nigeria: $F_{(2,61)} = 3.420$, $p < 0.05$, partial eta-squared (η_p^2 = .101). Hence, the null hypothesis is not accepted. This implies that the level of self-esteem is a significant determinant of marital dysfunction among married individuals in Anambra State, Nigeria. The size of effect shows that self-esteem explained (10.1%) (η_p^2 = .101) variance in marital dysfunction. To further show the margin of differences observed based on the level of self-esteem, the pair-wise comparison using Bonferroni was carried out, and the result is shown in Table 3 below:

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Table 3: Bonferroni Pair-wise Comparison Showing the Significant Differences in Marital Dysfunction

Based on the Level of Self-esteem

(I) Self-esteem	(J) Self-esteem	Mean Difference (I-J)	Std. Error	Sig.[b]
Low (mean = 31.811)	Moderate	-3.453	1.735	.153
	High	-4.010*	1.599	.044
Moderate	Low	3.453	1.735	.153
(mean = 35.264)	High	-.558	1.593	1.000
High (mean = 35.821)	Low	4.010*	1.599	.044
	Moderate	.558	1.593	1.000

Table 3 shows that after controlling for the effect of pre-test scores on marital dysfunction, participants with low self-esteem (mean = 31.811) had the lowest mean score on marital dysfunction, followed by participants with moderate self-esteem (35.264), and then those with high self-esteem (mean = 35.821). By implication, this means that an increase in self-esteem could result in an increase in marital dysfunction.

H0$_3$: There is no significant main effect of socio-economic status on marital dysfunction among married individuals in Anambra State, Nigeria.

Table 1 also shows that there was no significant main effect of socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria: $F_{(2,61)} = 1.346$, $p > 0.05$, partial eta-squared ($\eta_p^2 = .042$). Hence, the null hypothesis is not rejected. This implies that socioeconomic status has no significant impact on marital dysfunction among married individuals in Anambra State, Nigeria.

H0$_4$: There is a significant interaction effect of treatment and self-esteem on marital dysfunction among married individuals in Anambra State, Nigeria.

In addition, Table 1 shows that there was no significant interaction effect of treatment and self-esteem on marital dysfunction among married individuals in Anambra State, Nigeria: $F_{(4,61)} = 2.036$, $p > 0.05$, partial eta-squared ($\eta_p^2 = .118$). Therefore, the null hypothesis is not rejected. This implies that self-esteem did not significantly moderate the effect of treatment on marital dysfunction among married individuals in Anambra State, Nigeria.

H0$_5$: There is no significant interaction effect of treatment and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria.

Furthermore, Table 1 shows that there was no significant interaction effect of treatment and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria: $F_{(4,61)} = .355$, $p > 0.05$, partial eta-squared ($\eta_p^2 = .023$). Therefore, the null hypothesis is not rejected. This implies that the level of socioeconomic status does not significantly moderate the effect of treatment on marital dysfunction among married individual in Anambra State, Nigeria.

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H0$_6$: There is no significant interaction effect of self-esteem and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria.

Table 1 shows that there was a significant interaction effect of self-esteem and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria: $F_{(4,61)} = 3.563$, $p < 0.05$, partial eta-squared ($\eta_p^2 = .189$). Hence, the null hypothesis is not accepted. This implies that the level socioeconomic status significantly moderated the effect of self-esteem on marital dysfunction. The table went on to show that the effect of socioeconomic status on self-esteem accounted for 18.9% variance ($\eta_p^2 = .189$) in marital dysfunction. To further show where the differences lie, a pair-wise comparison using Bonferroni post hoc analysis was computed. The result is shown in Table 4 below:

Table 4: Bonferroni Pair-wise Comparison Showing the Interaction Effect of Self-esteem and

Socioeconomic Status on Marital Dysfunction

Self-esteem	Socio-Economic Status	Mean	Std. Error
Low	Low	31.417[a]	2.328
	Moderate	31.443[a]	2.430
	High	32.573[a]	1.500
Moderate	Low	41.356[a]	2.191
	Moderate	31.098[a]	2.378
	High	33.336[a]	1.796
High	Low	34.608[a]	1.533
	Moderate	38.559[a]	1.941
	High	34.296[a]	1.612

Table 4 shows that after controlling for the effect of pre-test marital dysfunction, the marital dysfunction scores of participants with different levels of self-esteem varies across levels of socioeconomic status. Participants with moderate self-esteem and moderate socioeconomic status had the lowest score on marital dysfunction (mean = 31.098), followed by those with low self-esteem and low socioeconomic status (mean = 31.417). Participants with low self-esteem and moderate socioeconomic status (mean = 31.443) as well as participants with low self-esteem and high socioeconomic status. Participants with high marital dysfunction scores are those with moderate self-esteem and low socio-economic status. Overall, it can be seen that marital dysfunction increases with both an increase in self-esteem and in socioeconomic status.

H0$_7$: There is no significant interaction effect of treatment, self-esteem, and socioeconomic status on marital dysfunction among married individual in Anambra State, Nigeria.

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Finally, Table 1 shows that there was no significant interaction effect of treatment, self-esteem and socioeconomic status on marital dysfunction among married individual in Anambra State, Nigeria: $F_{(8,61)} = 1.385$, $p > 0.05$, partial eta-squared ($\eta_p^2 = .154$). Hence, the null hypothesis is not rejected. This implies that self-esteem and socioeconomic status did not significantly moderate the effect of treatment on marital dysfunction among married individuals in Anambra State, Nigeria.

DISCUSSION OF FINDINGS

Based on the findings on the significant main effect of treatments (family system and cognitive behavioural therapies) on marital dysfunction among married individual in Anambra State, Nigeria, the result revealed that there is a significant main effect of treatments (family system and cognitive behavioural therapies) on the reduction of marital dysfunction among married individual in Anambra State, Nigeria. Hence hypothesis one was not confirmed statistically. Also, it shows that the mean score of participants exposed to family system therapy (FST) was better than the mean score for those that were exposed to CBT but not statistically significant, though it was statistically significantly different from those in the control group. Also, the mean score of participants exposed to Cognitive Behavioural Therapy (CBT) was significantly different from that in the control group. This is an indication that the participants that are exposed to both FST and CBT are significantly better than those in the control group. This is in line with the study of Malouff, Thorsteinsson, and Schutte (2007) that noted that family system therapy is much more beneficial than other therapies when it comes to controlling marital problems among married individuals. It was also found to be similarly effective as other psychological treatments. Additionally, compared to other treatment plans, family system therapy proved to be more successful in treating marital problems in married individuals. Apart from this comprehensive meta-analysis, more meta-analyses on the effectiveness of FST that concentrate on the handling of marital problems are required. Cuijpers, van Straten, and Warmerdam (2007) performed a meta-analysis, and the results were highly encouraging, demonstrating the effectiveness of FST therapy of marital problems. While Obalowo (2004) demonstrated the usefulness of cognitive behavioural therapy in treating marital dysfunction, Aderanti and Hassan (2011) claimed that FST and CBT are beneficial in treating marital dysfunction.

Also, findings on the significant main effect of self-esteem on marital dysfunction among married individuals in Anambra State, Nigeria show that self-esteem has a significant effect on marital dysfunction among married individuals in Anambra State, Nigeria. This implies that the level of self-esteem is a significant determinant of marital dysfunction among married individuals in Anambra State, Nigeria. On marital dysfunction, participants with low self-esteem had the lowest mean score on marital dysfunction, followed by participants with moderate self-esteem, then participants with high self-esteem. By implication, this means that an increase in self-esteem could result in an increase in marital dysfunction. This is in accordance with the study of Taghizadeh and Kalhori (2015), which indicated that most participants on marital satisfaction was moderately relative. A large number of samples reported positive self-esteem. A significant correlation was seen between marital discontent and factors such as self-worth, sexual gratification, and financial standing. Results from another research by Dzwonkowska, Lachowicz-Tabaczek, and Łaguna (2008) showed that marital satisfaction, length of marriage, and the age of the women are significantly correlated.

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Moreover, Fuladshahr women had a greater percentage of marital satisfaction. Furthermore, the results of Sadia and Shazia (2014) showed that self-esteem, religiosity, and optimism did not predict life satisfaction, but rather marriage satisfaction. The strongest correlation between religiosity and marital satisfaction was found.

Furthermore, findings on the significant main effect of socioeconomic status on marital dysfunction among married individual in Anambra State, Nigeria shows that socioeconomic status has no significant effect on marital dysfunction among married individuals in Anambra State, Nigeria. This implies that socioeconomic status has no significant impact on marital dysfunction among married individuals in Anambra State, Nigeria, that is, socioeconomic status is not a potential predictor on marital dysfunction among married individual in Anambra State, Nigeria. This is in agreement with the study of Quamma and Greenberg (1994) that a married person's socioeconomic situation may both increase marital problems and diminish depression. Additionally, it was discovered that social support might assist married people in controlling and reducing their marital problems. Socioeconomic status has been identified by Risi, Gerhardstein, and Kistner (2003) to be a protective factor that may lessen stress-related marital dysfunction issues in married people. According to a McCulloch's (1991) research, socioeconomic status has a motivating effect or a decrease in marital discord.

Moreso, findings on the significant interaction effect of the treatment and self-esteem on marital dysfunction among married individuals in Anambra State, Nigeria revealed that there is no significant interaction effect of treatment and self-esteem on marital dysfunction among married individuals in Anambra State, Nigeria. This implies that self-esteem did not significantly moderate the effect of treatment on marital dysfunction among married individuals in Anambra State, Nigeria. This is against the study of family system therapy (FST) as an intervention that aims to lessen marital problems, according to Biryukov (2006). The objective of this positive approach to therapeutic intervention is to assist married people in dealing with stressful situations more skillfully in order to lessen and avoid marital disruption and improve positive well-being. According to D'Zurilla and Nezu (2007), FST is predicated on a family relational model of managing marital dysfunction, which includes psychological, social, and health functioning. It is believed that this model is crucial in managing married people's relationships with one another.

Findings on the significant interaction effect of the treatments and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria revealed that there is no significant interaction effect of treatment and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria. This implies that socioeconomic status did not significantly moderate the effect of treatment on marital dysfunction among married individuals in Anambra State, Nigeria. This is against the study of Mahmood and Ghaffar (2014) who discovered strong negative connections between socioeconomic position and marital problems in addition to correlations between the two variables. Sagone and De Caroli (2013) observed that middle-married people who experienced high socioeconomic status felt more equipped to handle novelty in a variety of areas of human functioning and, particularly in an educational setting, this decreased their likelihood of experiencing marital dysfunction outcomes.

Also, findings on the significant interaction effect of self-esteem and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria show that there was a significant interaction effect of self-esteem and socioeconomic status on marital dysfunction

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among married individuals in Anambra State, Nigeria. This implies that the level socioeconomic status significantly moderated the effect of self-esteem on marital dysfunction. Hence, hypothesis six was statistically not confirmed. The marital dysfunction of participants with different levels of self-esteem varies across levels of socioeconomic status. Participants with moderate self-esteem and moderate socioeconomic status had the lowest score on marital dysfunction, followed by those with low self-esteem and low socioeconomic status, participants with low self-esteem and moderate socioeconomic status, and then participants with low self-esteem and high socioeconomic status. Participants with the high marital dysfunction scores are those with moderate self-esteem and low socioeconomic status. Overall, it can be seen that marital dysfunction increases with an increase in self-esteem and socioeconomic status together. This is in line with the study of Robinson and Cameron (2012) who discovered that persons with lower self-esteem and their partners had less marital problems and a lower level of commitment to their relationships compared to those with greater self-esteem and their spouses. Self-esteem has both actor and partner impacts on marital dysfunction, according to research by Erol and Orth (2013), who used the actor-partner interdependence model and data from five separate samples of married people. The findings of Bélanger, Di Schiavi, Sabourind, Dugalad El Baalbaki, and Lussier (2014) not only supported the existence of a link between married people's self-esteem and marital dysfunction, but also showed that high levels of self-esteem and marital dysfunction are linked to a reduction in avoidance and an increase in problem-solving techniques.

The findings on significant three-way interaction effect of treatments (family system and cognitive behavioural therapies) and moderating variables (self-esteem and socioeconomic status) on marital dysfunction among married individual in Anambra State, Nigeria show that there is no significant interaction effect of treatment, self-esteem and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria. This means that there is no significant interaction effect of treatment, self-esteem and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria. This is against the study of Dollete, Steese, Phillips, and Matthews (2004); family system therapy may help married people experience less marital problems. Wentzel (1998) discovered that family system treatment had a motivating effect on dysfunctional marriages. The results of Quomma and Greenberg (1994), who discovered that married people would experience marital dysfunction if they received less family system treatment from various sources, provide credence to this research. Therefore, FST may be useful in lowering marital dysfunction among married people in Anambra State, Nigeria.

CONCLUSION

The study investigated the effectiveness of family system and cognitive behavioural therapies on the reduction of marital dysfunction among married individuals in Anambra State, Nigeria. It was discovered that there is a significant main effect of the treatments (family system and cognitive behavioural therapies) on marital dysfunction among married individuals in Anambra State, Nigeria. Family system therapy (FST) was better than those exposed to CBT but not statistically significant, though it was statistically significantly different from those in the control group. Also, self-esteem has a significant effect on marital dysfunction among married individuals in Anambra State, Nigeria. This means that there is no significant main effect of self-esteem on marital dysfunction among married individuals in Anambra State, Nigeria.

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Furthermore, socioeconomic status has no significant effect on marital dysfunction among married individuals in Anambra State, Nigeria. By implication, there is a significant main effect of socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria.

Moreso, there is no significant interaction effect of treatment and self-esteem on marital dysfunction among married individuals in Anambra State, Nigeria. This means that there is no significant interaction effect of treatment and self-esteem on marital dysfunction among married individuals in Anambra State, Nigeria. There is no significant interaction effect of treatment and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria, that is, treatment and socioeconomic status when combined have no critical effect on marital dysfunction among married individuals in Anambra State, Nigeria. Also, there was a significant interaction effect of self-esteem and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria. This means that there was a significant interaction effect of self-esteem and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria. There is no significant interaction effect of treatment, self-esteem and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria. This means that there is no significant interaction effect of treatment, self-esteem and socioeconomic status on marital dysfunction among married individuals in Anambra State, Nigeria.

RECOMMENDATIONS

The following recommendations are given based on the findings of this study:

1. The family system and cognitive behavioural therapies have been proven to be effective in the management of marital challenges. Hence, they should be adopted during counselling sessions. This will help in the reduction of marital dysfunction. Professional counsellors can adopt the rudiment of cognitive behavioural therapy in helping married individuals regarding marital dysfunction.

2. Married counsellors are advised to consider the self-esteem of the married individuals in counselling because their marital dysfunction levels differ as well as the way they react and handle their marital dysfunction.

3. More so, married individuals with marital dysfunction challenges should be helped in building their self-esteem first, so as to manage their marital crisis.

4. Self-esteem should be considered during counselling due to the fact that the experience of marital dysfunction differs; hence, by implication the response to therapy might differ.

5. Couples should be encouraged to focus more on their strength than weaknesses in marriages, where focusing on one's strength could help to foster bond in marriage.

6. Marriage counselors should organize programs for married individuals on marital harmony.

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