

The Effect of Traditional Marital Counseling Therapy (TMCM) on Marital Distresses among Married Couples in Ghana

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Abstract

The study aims at determining the impact of the Traditional Marital Counseling Model (TMCM) on marital distresses among married couples in Ghana. The study adapted versions of the Session Process and Outcome Measures-Client version (SPOM-C) and the Revised Dyadic Adjustment Scale (RDAS) questionnaires to measure therapy outcome for 50 married couples who were selected through stratified proportionate random sampling technique to participate in a descriptive-correlational-experimental research design. Disparity analyses were done using the Predictive Analytics Software (PASW) 18 guide to Data Analysis. Descriptive frequencies were used to analyze the data on the levels of marital distress. Disparity mean values within the sample were measured by paired t-test technique. Correlation between outcome of therapy for TMCM and level of marital distress were measured by Pearson correlation coefficient. The study found that TMCM has a significant effect on the marital distresses of the married couples. Though TMCM is better for counseling clients with various types of marital distresses, it is most effective in situations where clients present severe marital distress. Therapists should use TMCM especially for clients showing severe marital distress.

Keywords: *Traditional Marital Counseling Model (TMCM), Marital Distress, Married Couples, Marriage and Family Counseling, Marital Therapy.*

Introduction

Generally, there is a need for effective marriage and family counseling in Ghana. Other approaches exist for offering marriage and family counseling. These include behavioral strategies, communication skills training, systematic interventions, integrated couples' therapy, emotionally focused couple therapy, imago therapy, Gottman's sound marital house theory, and the cognitive-behavioral marital therapy (CBMT). Despite the existence of all these models of marital therapy, family and marriage counseling is yet to have a documented impact in helping clients with marital distresses deal with the problems. In light of this need, the researcher proposes and measures the impact of the Traditional Marital Counseling Model (TMCM) on marital distresses among married couples in Ghana.

Literature review

The Traditional Marital Counseling Model (CBMT).

Traditional Marital Counseling Model (TMCM) is a self-determined term that the researcher uses to describe the dominant model of therapeutic intervention at the instance of marital distress in African marriages. As indicated by Bakadzi Moeti and Hildah L. Mokgolodi in Botswana, the origin of marital counseling in Africa cannot be separated from the beginning of the culture itself (Moeti & Mokgolodi, 2017: 65-66). Marital therapy begins right from the performance of the customary marriage. In most African societies, the experiential tales of older folks concerning marriage is key. Both elderly men and women counsel the couple on the ingredients of a successful home. In Ghana, it is a common practice for each of the contracting families to present two individuals as a bulwark of the marriage. These individuals are expected to be the first point of contact for the couple in all matters concerning the marriage for which they need counsel. For this reason, the individuals selected are supposed to be of good behavior and personal piety.

Though the counseling model, referred to as Traditional Marital Counseling Model (TMCM), has generally been considered effective in helping African couples deal with their marital distress, no

empirical data has been provided to support this general assertion. The current research accesses the efficacy of TMCM in assisting marital couples to deal with their marital distress. The Traditional Marriage Counseling Model (TMCM) operates within the framework of the African philosophy of healthy marriage and the role theory.

Across most African communities, marriage is considered a basic union that enables society to promote "life" through "procreation" (Kyalo, 2012: 211). For this reason, dissatisfaction in marriage was never encouraged. All individuals of the community were expected to maintain marriage stability at all cost. The marital relationship, also, laid some "dignity" on the couples (Kyalo, 2012: 214). Both husbands and wives drew their marital roles from this dignity. Non-performance of these roles led to marital dissatisfaction. Thus the general cause of dissatisfaction in African marriages was the non-performance of spousal roles in the marital relationship (Nwoye, 2000: 348; Kyalo, 2012: 216).

The main assumption of TMCM is that individual, marital distress negatively affects members of the household as well as the larger society leading to problems in the marriage, family, and corporate relationships. This implies that by helping couples with marriage and family-related problems to solve, adjust, or cope with their marriage and family-related distress, marriage and family counseling can subsequently aid them to make necessary changes in their behaviors that will cause them to enjoy their marital, family, and corporate relations. Thus, TMCM forms the basis of this study. Consequently, data collection, data management, and data analysis and interpretation are done from the perspective of this theory. From this perspective, the study probes ways to enhance marriage and family counseling in Ghana through TMCM.

A study by E. M. Gichinga (2005) identified "communication, physical/emotional abuse, parenting challenges, trauma (chronic and terminal illness), infidelity, alcohol/substance abuse, finances, infertility/childlessness, in-laws, and sexual dysfunctions" as the cause of marital distress in African marital relationships (cited in Sodi, Esere, Gichinga, & Hove, 2010: 335). T. Sodi and E. Sodi added "lack of trust (suspicions and extramarital affairs)" to the list of factors that cause marital distress (Sodi et al., 2010: 335). At the onset of marital distress, the complaining couple is expected to follow a three-stage mediation (Sodi, Esere, Gichinga, & Hove, 2010: 336). First, couples must try self-mediation. This is a personal attempt to resolve the underlining causes of marital distress without involving a third party. In the second stage, couples are expected to inform the individuals given to them by their respective families during the marriage contract. In the third stage, the matter is brought to a wider audience for hearing and arbitration. Normally, the audience consists of close family members of the couples.

Earlier research on indigenous African counseling has indicated "group counseling," song therapy, proverb/metaphor therapy as dominant approaches used in marital therapy (cf. Moeti & Mokgolodi, 2017: 68-70). In the current study, the Traditional Marital Counseling Model (TMCM) employs these traditional counseling approaches in addition to varied approaches from the Western context. These Westernized approaches include Experiential Family Therapy (EFT), Structural Family Therapy (SFT), Cognitive-Behavioral Marital Therapy (CBMT), Integrative Behavioral Couple Therapy (IBCT), Multi-Systemic Therapy (MST), Solution-Focused Brief Therapy (SFBT), and Narrative Therapy (NT). The option to use any of these approaches or a combination of them depends on the training of the therapist and the nature of the client's marital distress.

In Experiential Family Therapy (EFT), the therapist assists clients of marital distress in probing personal perception and emotions that underline the feelings of dissatisfaction in the marital relationship. The therapist helps clients focus on the positive aspects of the other spouse as well as on the positive aspects of the marital relationship. TMCM also uses Structural Family Therapy (SFT). In this type of therapy, the therapist assists clients in identifying general areas in the structure of the family that needs modification. Once these changes are made, the structural family therapist assumes couples can easily work out their marital challenges or attachment difficulties.

TMCM sometimes employ Cognitive-Behavioral Marital Therapy (CBMT). In using this approach, the TMCM therapist focuses on aiding the client to modify his/her pattern of thought concerning the other spouse and the entire marital relationship. The TMCM therapist believes that modifying clients thought patterns about the other spouse and the entire relationship would help restore marital stability. In seeking to understand the background of clients, TMCM therapist may employ the Integrative

Behavioral Couple Therapy (IBCT). This approach enables the therapist to gain insight into presenting marital distress so the therapist can assist clients in accepting each other.

The TCM therapist may also employ the Multi-Systemic Therapy (MST). In this therapeutic approach, the therapist holds the therapeutic session within the environment of the client. While the move makes counseling accessible to clients, MST also enables the therapist and clients to address comprehensive factors that subtly contribute to marital and family distress. The TCM therapist has the option of using the Solution-Focused Brief Therapy (SFBT). Focused on resolving the presenting marital distress, TCM uses the SFBT to design short-term intervention plans that aim at investing clients with the ability to determine their solution to presenting marital distress.

In following the procedure of TCM, one realizes that it partially uses Narrative Therapy (NT). By listening and re-listening to the client, the TCM therapist affords clients the opportunity to examine the narratives that drive their thoughts, behavior, and feelings. Once clients become aware of this, TCM therapist assists them in enhancing specific positive narratives that ensure marital stability. Sometimes, the therapist encourages the client with real-life stories of an anonymous individual who had similar situations but was able to work through it.

Nwoye has attempted formalizing the counseling stages of the Traditional Marital Counseling Model (TCM). Terming his procedures as "mediatorial session," Nwoye describes counseling in African societies as a system of "claim, and counter-claim" in the presence of "mediating elders" who function as "jury" (Nwoye, 2000: 348-349). Nwoye's 'mediatorial session' is divided into three major stages. These are the social stage, the initial hearing, and the reconciliation stage. In the first stage, the couple interacts with the counselor. The goal of this stage is to gain first-hand insight into the marital distress and also to establish the beginning of a hearing.

This stage overlaps into the second stage of the hearing. In the initial stage is divided into two- the first and second hearings. In the first hearing, the therapist listens to the individual version of marital distress. Usually, the counselor meets individuals couples on alternate days. After both couples has narrated their version of the marital distress, the counseling enters the second phase of the second stage. During this phase, the counselor engages individual clients separately. The purpose is to enable them to clarify and modify maladaptive thoughts, feelings, and behaviors that sustain marital distress.

Also, the counselor helps clients to identify personal areas of negative thoughts, feelings, and behaviors through indigenous modeling. These models involve the use of "proverbial observations, metaphors, short wisdom story genres, and some fictional ideologies" (Nwoye, 2000: 355). Generally, this stage ends with client conscious of negative actions as well as personally-designed solutions to the presenting marital distress.

The third stage is divided into two phases. In this stage, the therapist meets both couples together and directly point out the fault of each other in the session. This is followed by specific admonition on marital roles and societal values to the concerned couple. The first phase of this stage ends with an exchange of apologies or acceptance of the apology. The second phase of the third stage is the apex of the TCM. In this phase, the couple actively expressed their forgiveness and acceptance of one another. Activities include warm embrace between couples, the presentation of money or "appeasement gift," and the preparation of the delicacies for the other spouse (Nwoye, 2000: 357).

The current study uses Nwoye's "mediatorial session" as procedures for the Traditional Marital Counseling Therapy (TCM). Some participants in this research will be assigned to this therapy to access its efficacy in helping clients deal with their marital distress. Two factors limit the efficacy of the Traditional Marital Counseling Model (TCM). First, it is semi-structured. Though it appears to have identifiable stages, sessions within each stage and the duration each session takes are not readily observable. It appears these hidden sessions vary, both in terms of number and in-session duration. Second, the seemingly fluid nature of this therapy does not easily enable the use of the psychological instrument in the therapeutic process. In the current study, the researcher ensured that these factors did not disrupt the use of the model.

Marital Distress

Marital distress describes general feelings of dissatisfaction that occur in the marital relationship (Reis & Sprecher, 2009: 344; Halford, 2003: 3). DSM-V has placed marital distress among the category of "other conditions" that need clinical attention (cited in Barlow, 2014: 703). Even in this

category, marital distress is marked with the "'V code' of relationship distress with spouse or intimate other" (cited in Barlow, 2014: 703). Scholars have observed that marital distress causes physical, mental, and emotional suffering than most "DSM" recognized "disorders" (Barlow, 2014: 703). Additionally, marital distress contributes to some disorders such as depression that impacts "mental health, physical health," and "family health" of partners in the marital relationship (Fincham & Beach, 1999: 48, 49; Greene & Burleson, 2008: 149; Carlson & Dermer, 2017: 1008). Lebow et al. indicated that marital distress has a close association with "bipolar disorder, alcohol use disorders, and generalized anxiety disorder" (Lebow, Chambers, Christensen, & Johnson, 2012: 146).

Inadequate or lack of "communication" between couples have been generally ascribed as the cause of marital distress (Cox & Brooks-Gunn, 2014: 52; Jacob, 2013: 147). Michael J. Salamon thinks "specific communication styles" are the real cause of marital distress (Salamon, 2008: 113). Elizabeth van Acker noted that lack of "time" for each other and "financial" challenges were some causes of marital distress (van Acker, 2017: 21). In addition to poor communication skills between couples, Chris Segrin and Jeanne Flora observed that other "dyadic skills" including "problem-solving and coping between spouses" as well as poor "relational skills" between couples cause marital distress (Segrin & Flora, 2011: 252). Contrary to the opinion of some researchers, D. Eugene Mead has found that "gender" only deepens marital distress but does not cause it (Mead, 2002: 299). In line with cognitive-Behavior Marital Therapy (CBMT), Donald H. Baucom and Norman Epstein argue that the interplay of some cognitive factors underlines marital distress. These factors are an individual couple's "perceptions" about actual events, "attributions" (that is an individual couple's explanation of life events), "expectancies" (individual couple's projection of consequent events), "assumptions" concerning reality and interactions between life activities, and "beliefs or standards" (that is an individual couple's notion of how things are supposed to be) (Baucom & Epstein, 2013: 47).

Some researchers have attempted to categorize marital distress. Irving E. Sigel and Gene H. Brody, for example, classified marital distress into "physically aggressive, verbally aggressive, withdrawn, and nonaggressive" (Sigel & Brody, 1990: 197). The current study categorizes marital distress into mild (from 47 to 42, RDAS), moderate (from 41 to 32, RDAS), and severe marital distress (below 31, RDAS). This classification is based on couples score on the Revised Dyadic Adjustment Scale (RDAS).

Methodology

The descriptive-correlational-experimental design was used in this study. A descriptive survey involving the sample enabled the study to present a detailed state of the interaction between marital distress and marital counseling in Ghana. The correlational aspect of the study made it possible for the researcher to measure the relationship between socio-demographic variables and the outcome of therapy for TCM. Using experiment, the causal relationship between marital distress and TCM for marital counseling was assessed.

The proportionate stratified random sampling technique was used (Henry, 1990: 29; Babbie, 1990: 85; Cochran, 1953: 65; Kish, 1965: 21; Fowler, 1993: 15; MacNealy, 1999: 156). The rationale for using this technique was to ensure the equal representation of all characteristics of married couples in Ghana relevant for the study. Hundred (50) heterosexually married couples (one hundred (100) heterosexually married individuals) participated in the study.

A six-session TCM therapy was designed for the research group. The total duration of the treatment plan was ten (10) days. In-session duration ranged from three hours to six hours of therapy. The first session focused on inaugurating the therapy. Activities in this session corresponded with Nwoye's social stage. The counselor established rapport with the couples set the counseling goal and established the ground rules for therapy. In the second session, beginning Nwoye's initial hearing stage, the counselor met the wife alone in her home. The reason was to understand the wife's version of the underlining causes, the present state of affairs, and the consequences of marital distress.

In the third session, ending Nwoye's initial "hearing stage," counselor met the husband at a venue determined by the husband. Following Nwoye's procedure, this therapeutic session occurred two days after the therapist had met the wife. The choice of the venue engendered trust between the therapist

and the client. The main concern of the counselor was to understand the husband's version of the underlining causes, the present state of affairs, and the consequences of marital distress.

In the fourth session, beginning Nwoye's second hearing stage, the counselor met again with the wife at the same venue as in the first meeting. The focus of this meeting was to assist the wife in examining her narrative of marital distress. Accordingly, the counselor sought to clarify, rephrase, and reflect on the thoughts, feelings, and behavior of the wife. The role of the wife in the marital relationship was the center-stage of the discussion. At the end of this session, the wife had an objective assessment of the underlining causes of marital distress. Further, the wife gained insight into how she could focus on her duty to save her marriage from general dissatisfaction. In situations where wives were found to be the guilty party, the counselor encouraged her to express reconciliatory gestures at the last session of therapy.

The fifth session, ending Nwoye's second hearing stage, occurred two days after the counselor had met the wife. The venue was the same as it was in the first hearing with the husband. The goal of this session was to help the husband clarify and evaluate the personal contribution to marital distress. From the perspective of the husband's role in the marital relationship, the counselor assisted the husband in arriving at personal ways of resolving marital distress. As in the fourth session with the wife, the counselor encouraged the husband to express reconciliatory gestures at the last session of therapy. This encouragement only happens where husbands were the guilty parties.

The last session of TCM corresponds with Nwoye's final stage of reconciliation. It took place a day after the fifth session. In this session, the counselor meets both couples. The session aims to provide couples with insight regarding the cause(s) of marital distress. Through metaphors, proverbs, and narration of vicarious experiences concerning societal expectations for each couple as well as about the entire marital relationship, the counselor helped couples to focus on the significance of forming a functional alliance to make the marriage work. The counselor ensured that discussions were equitable to each of the couple. The expression of reconciliatory gesture from one of the couples was appropriately responded to by the other couple. This was followed by an affirmation of unity. During the therapy, couples either engaged in a warm embrace or compensated the offended spouse using cash or kind.

Two weeks after TCM ended, counselor followed up on the couple. In this follow-up, couples individually filled out the RDAS for the second time. Average scores for the couple were stored for later usage. Also, couples filled out a questionnaire measuring their perception of the outcome of counseling. Average scores for the couple were stored for later usage.

Two research instruments were used in gathering data for the study- the SPOM-C and the RDAS. The study adapted the Session Process and Outcome Measures-Client version (SPOM-C) to gather information about married couples' perception of the outcome of the marriage and family counseling from both the research group and the comparison group. The adapted version of the SPOM-C comprised of four sub-scales. These were the socio-demography section, the Helping Skills Measure (HSM-C), Session Evaluation Scale-Client Version (SES-C), and the Relationship Scale-Client Version (RS-C). The demography section gathered socio-demographic information about the research sample. It included the level of marital distress among the study sample.

The HSM-C uses a 13-item scale to measure couples' evaluation of the performance of counselors during the exploration, insight, and action stages of marriage and family counseling. All items in this sub-scale begin with the stem "in this session, my helper..." RS-C subscale consisted of four items all beginning with the stem "in this session, I..." The SES-C subscale included four items each built on the stem "I..." Thus HSM-C instrument consisted of 21 items. It uses a five-point Likert scoring scale that ranges from strongly disagree (1) to strongly agree (5). Scoring is accumulated. The higher the score, the more effective the married couple (client) perceives of the marriage and family counseling.

Test-retest analysis by Hill and Kellems (2002) on the threefold structure of the SPOM-C produced a reliability alpha co-efficient 0.73, 0.71, and 0.82 for the exploration, insight, and action stages of the counseling process. Also, their study found a validity alpha co-efficient of $r=0.43$, $p < 0.001$, $r=0.44$, $p < 0.001$, and $r=0.60$, $p < 0.001$ for the exploration, insight, and action stages of counseling.

The second instrument was a slightly modified version of the Revised Dyadic Adjustment Scale (RDAS). It was used to screen initial respondents and also to measure the level of marital distress

among the research sample. The RDAS is an updated version of the Dyadic Adjustment Scale (Spanier, 1976: 15; Busby, Christensen, Crane, & Larson, 1985: 289-290). Apart from the modified socio-demographic measurement, the RDAS uses a 14-item on a 5- or 6-point scale to measure marital adjustment in three key areas. These are consensus, satisfaction, and cohesion. The total score of the RDAS is 69. Scores of 48 and above indicate greater marital stability and scores of 47 or below indicates the existence of marital instability.

In this study, average scores of couples are used to determine the presence or otherwise of marital distress. While average couple scores of 48 and above were considered as non-distress/distress free, average couple scores of 47 or below were considered to be distressed. Among the distressed couples, average couple scores between 47 and 42 were regarded as mild distress; 41-32 was regarded as moderate distress, and 31 and below were regarded as severe distress. The RDAS has a reliability of ".90" and a "construct validity of .68 ($p < .01$)" (Busby, Christensen, Crane, & Larson, 1985: 290; Crane, Middleton, & Bean, 2000: 53). The efficacy of the RDAS in determining the presence of marital distress has been attested to by many studies (Anderson et al., 2014: 530; Turliuc & Muraru, 2013: 49). The RDAS has been replicated in another socio-cultural context (Hollist et al., 2012: 348).

Comparative and disparity analysis were done on research data using the Predictive Analytics Software (PASW) 18 Guide to Data Analysis. Descriptive frequencies were used to analyze data on participants' levels of marital distress. Disparity mean values within the sample were analyzed by a paired t-test technique. Correlation between the outcome of therapy for TMCM and type of marital distress was measured by Pearson correlation coefficient.

The researcher followed the code of ethics of the American Association for Marriage and Family Therapy (AAMFT) in involving human beings as participants for this study. By Principle V ("Responsibility to research participants"), the researcher ensured that participants volunteered their participation in the study. Also, interested participants were informed of their right to withdraw from the study at their volition. Again, the researcher assured participants that personal information shared was strictly limited to this study.

Discussions

Table 1.1. Distribution of marital distress before and after therapy for TMCM

Type of Marital Distress	Before		After	
	Frequency	Percent	Frequency	Percent
Severe	29	58.0	-	-
Moderate	8	16.0	5	10.0
Mild	13	26.0	45	90.0
Total	50	100.0	50	100.0

Table 1.1 presents distribution scores and frequencies for the three types of marital distress for both the before and after therapy for the sample. Frequencies and scores for before therapy were: severe was 29 (58%); moderate was 8 (16%), and mild was 13 (26%). Frequencies and scores for after therapy were: severe was 0 (0%); moderate was 5 (10%), and mild was 45 (90%). Table 1.1 indicates a significant impact of therapy on the status of marital distress for the sample.

Table 1.2. Type of marital distress and therapy outcome for TMCM

Marital Distress = Severe to moderate

Variable	Obs	Mean	Std. Err	Std. Dev.	[95% Conf. Interval]	
After therapy	4	40	0.408	0.816	38.700	41.299
Before therapy	4	25.5	1.5	3	20.72	30.27
Difference	4	14.5	1.658	3.316	9.22	19.77

Mean (diff) = mean (Marital distress after therapy - Marital distress before therapy) $t = 8.74$

Ho: mean (diff) = 0 degrees of freedom = 3

Ha: mean (diff) < 0

Ha: mean (diff) \neq 0

Ha: mean (diff) > 0

Pr (T < t) = 0.9984

Pr (|T| > |t|) = 0.0031

Pr (T > t) = 0.0016

The analysis indicates the marital distress for four (4) participants moved from the severe state to the moderate state with a mean difference of 14.5 from before and after therapy provision.

Marital Distress = Severe to Mild

Variable	Obs	Mean	Std. Err	Std. Dev.	[95% Conf. Interval]	
After therapy	14	44.5	0.429	1.605	43.57	45.43
Before therapy	14	27	0.907	3.396	25.039	28.96
Difference	14	17.5	0.982	3.674	25.038	28.961

Mean (diff) = mean (Marital distress after therapy - Marital distress before therapy) $t = 17.82$

Ho: mean (diff) = 0 degrees of freedom = 13

Ha: mean (diff) < 0

Ha: mean (diff) \neq 0

Ha: mean (diff) > 0

Pr (T < t) = 0.9984

Pr (|T| > |t|) = 0.0031

Pr (T > t) = 0.0016

The analysis indicates the marital distress for fourteen (14) participants moved from the severe state to the mild state with a mean difference of 17.5 from before and after therapy provision.

Marital Distress = Severe to Distress free

Variable	Obs	Mean	Std. Err	Std. Dev.	[95% Conf. Interval]	
After therapy	11	51	0.894	2.966	49.007	52.992
Before therapy	11	27.818	0.970	3.219	25.655	29.980
Difference	11	23.181	1.060	3.516	20.819	25.544

Mean (diff) = mean (Marital distress after therapy - Marital distress before therapy) $t = 21.866$

Ho: mean (diff) = 0 degrees of freedom = 10

Ha: mean (diff) < 0

Ha: mean (diff) \neq 0

Ha: mean (diff) > 0

Pr (T < t) = 1.0000

Pr (|T| > |t|) = 0.0000

Pr (T > t) = 0.0000

The analysis indicates the marital distress for eleven (11) participants moved from the severe state to distress free state with a mean difference of 23.18 from before and after therapy provision.

Marital Distress = Moderate to Mild

Variable	Obs	Mean	Std. Err	Std. Dev.	[95% Conf. Interval]	
After therapy	3	45.666	0.333	0.577	44.232	47.100
Before therapy	3	35	1.527	2.645	28.427	41.572

Difference	3	10.666	1.666	2.886	3.495	17.837
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Mean (diff) = mean (Marital distress after therapy - Marital distress before therapy) $t = 6.40$

Ho: mean (diff) = 0 degrees of freedom = 2
 Ha: mean (diff) < 0 Ha: mean (diff) \neq 0 Ha: mean (diff) > 0
 Pr (T < t) = 0.9882 Pr (|T| > |t|) = 0.0236 Pr (T > t) = 0.0118

The analysis indicates the marital distress for three (3) participants moved from the moderate state to the mild state with a mean difference of 10.66 from before and after therapy provision.

Marital Distress = Moderate to distress free

Variable	Obs	Mean	Std. Err	Std. Dev.	[95% Conf. Interval]	
After therapy	4	50.25	0.854	1.707	47.53	52.96
Before therapy	4	35.5	0.5	1	33.908	37.09
Difference	4	14.75	1.315	2.629	10.565	18.935

Mean (diff) = mean (Marital distress after therapy - Marital distress before therapy) $t = 11.22$

Ho: mean (diff) = 0 degrees of freedom = 3
 Ha: mean (diff) < 0 Ha: mean (diff) \neq 0 Ha: mean (diff) > 0
 Pr (T < t) = 0.9992 Pr (|T| > |t|) = 0.0015 Pr (T > t) = 0.0008

The analysis indicates the marital distress for four (4) participants moved from the moderate state to distress free state with a mean difference of 14.75 from before and after therapy provision.

Marital Distress = Mild to Distress free

Variable	Obs	Mean	Std. Err	Std. Dev.	[95% Conf. Interval]	
After therapy	9	50.666	0.5	1.5	49.51	51.81
Before therapy	9	44.555	0.603	1.810	43.16	45.97
Difference	9	6.111	0.388	1.166	5.21	7.00

Mean (diff) = mean (Marital distress after therapy - Marital distress before therapy) $t = 15.71$

Ho: mean (diff) = 0 degrees of freedom = 9
 Ha: mean (diff) < 0 Ha: mean (diff) \neq 0 Ha: mean (diff) > 0
 Pr (T < t) = 1.0000 Pr (|T| > |t|) = 0.0000 Pr (T > t) = 0.0000

The analysis indicates the marital distress for nine (9) participants moved from the mild state to distress free state with a mean difference of 6.11 from before and after therapy provision.

Comparing the means, it is evident that the TMCM therapy was significant among the participants with moderate marital distress to distress free of 14.75, then to those in the moderate to mild state of 10.66 mean difference for before and after therapy and from the mild state to the distress free state record a mean difference of 6.11. The study found out that under the TMCM, the therapy effect was great among the participant with severe marital distress moving to distress free after the therapy application with a mean difference of 23.18. The efficacy of TMCM lays in its flexibility to vary various approaches to tackle the complexities of tension the clients are likely to face in the study setting.

Conclusion

In order to identify ways of improving family and marriage counseling in Ghana, current study tested the impact of traditional marital counseling model (TMCM) on marital distresses among married couples in Ghana. The research design was descriptive-correlational-experimental. It revealed that TMCM had significant impact on the various types of marital distresses among married couples in Ghana. It significantly caused marital distress to move from moderate to mild, moderate to distress free, and mild to distress free. The flexibility of TMCM will enable both therapists and clients in Ghana to explore their total marital experience to resolve, adjust, or cope with marital tensions. Though TMCM is better for counseling clients with various types of marital distresses, it is most effective in situations where clients present severe marital distress. Therapists should use TMCM especially for clients showing severe marital distress.

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