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Original Article

Marital Commitment and Mental Health in Different Patterns of Mate Selection: A Comparison of Modern, Mixed, and Traditional Patterns

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Abstract

Objective: Marital commitments and mental health are the important indicators of marital quality. Considering the modern and mixed marriage pattern in recent years, compared to the traditional pattern, as well as the increase in divorce rates due to reduced marital commitment, the present study was conducted to compare marital commitment and mental health in various patterns of mate selection among married women.
Method: This cross-sectional study was performed on 160 married women aged 15-49 years in Babol city, Iran, who were selected by convenience sampling from health centers under the auspices of Babol University of Medical Sciences. Data collection tools included the spouse-selecting style, marital commitment (Adams and Jones), and general health questionnaires. Data analysis was performed in SPSS V.25 software, using analysis of variance (ANOVA), and Chi square tests.
Results: Results showed that the mean score of marital commitment and its three dimensions (commitment to spouse, commitment to marriage and sense of commitment); general health; physical, anxiety and sleep disorders; as well as social function of married women are not significantly different in traditional, mixed and modern marriage patterns. There was a significant difference in the mean score of depression between traditional, mixed and modern marriage patterns. Pairwise, ANOVA revealed that the mean of the depression score was significantly higher in traditional marriage than in the mixed marriage pattern ($P = 0.012$). Different marriage patterns had statistically significant differences in demographic variables such as age, the place of birth of the wife and the husband, duration of marriage, number of children and the level of education ($P < 0.05$).
Conclusion: It seems that there is a kind of convergence in marital commitment in various patterns of marriage among married women in Babol city.

Key words: *Commitment; Mental Health; Marriage Pattern; Mate Selection*

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Marriage is the most common custom in all societies, which is known as the most important type of relationship due to its crucial role in the development of family and survival of generations (1). In other words, marriage is the best type of relationship in response to human needs as well as a main stage of human development (2). Marriage is a real need that plays an essential role in instilling positive thinking about emotional and marital satisfaction of couples in a family (3). Marriage was traditional in the past. In this way, the families, especially the man's family, chose the desired person based on their situation, and the man and woman got married with the consent of their families but without prior knowledge of each other (4). In this pattern of marriage, the demands of the youth were not taken into account. The emergence of new methods of choosing a spouse (via the Internet, workplace, acquaintances, place of study, etc.) has prompted people to make their choices more independently from the family (5). Over time, another pattern of marriage has been introduced into our culture, in which the parties marry after getting to know each other or by creating an emotional relationship at their own discretion, which is called the modern or non-traditional way of marriage (4). In the twenty-first century, traditional marriages have become less common and the majority of young people in most cultures select their own spouse with or without parental approval. A mixed pattern of marriage has also been identified, which means lack of interaction and friendship before marriage with satisfaction during marriage (6, 7).

One of the fundamental challenges facing societies that are transitioning from the traditional to the modern pattern is the current traditions of the society, which stand face to face with modern values. It is difficult to adapt traditional beliefs and values to modern versions; because, modern foundations and values are not compatible with most of the current traditional values of societies in transition. From this point of view, it is not possible to integrate these two value systems, which is neither possible nor advisable. However, the process of mixing values during the transition from the traditional to the modern society is associated with incompatibility and value multiplicity, which can cause harm to societies (8). On the other hand, marital commitment and mental health have been mentioned as indicators of marital quality (9, 10).

Marital life satisfaction can be considered as the success and desired function of a marriage, which is the result of various factors, including marital compromise and the couple's sense of commitment to each other, and is one of the important predictors of marital continuity and stability (11). Commitment in a relationship means how much a person evaluates the relationship to continue and to what extent he/she has a sense of security, peace and trust (12, 13). It shows the desire to continue the marriage, have marital stability, express love and solve problems more appropriately (9). In this regard, Gao *et al.* reported that one of the characteristics of a healthy family is the sense of commitment of couples towards each other. Commitment means that family members are loyal to each other when they are sad and happy, and during pleasant and unpleasant events of life (14). Marital commitment includes three dimensions: personal, moral, and structural. Personal commitment means a person's attention and willingness to continue a marital relationship. This commitment is a reflection of the individual's understanding of his or her partner and relationship, as well as the value of the association to the individual (11). Moral commitment reflects the degree to which a person feels committed to continuing a relationship. Based on this type of commitment, the values and beliefs are directional, according to which the person behaves correctly in the relationship (15). Finally, structural commitment indicates that people think that they must maintain the relationship for reasons outside of one's connections (i.e. factors such as culture and custom) (16).

Commitment is a major factor in marital life and plays an important role in maintaining the continuity and health of marriage. Its absence destroys the marriage contract and shakes the foundation of the family and may therefore lead to divorce (17). People with high marital commitment attempt to augment satisfaction with their relationship and show less interest in thinking about alternative situations that can cause insecurity in their spouse (18). Also, the more mentally healthy a person is, the higher his or her marital commitment and obligation to the covenant is expected to be. There is a two-way association between people's mental health and romantic and friendly family relationships, and a person's mental health increases marital satisfaction, quality of life and consequently marital commitment. Therefore, it is suggested that general programs be implemented to improve the mental health of couples in the community (19). In fact, people with better mental health feel more responsibility toward their spouse and family. Moreover, people with good mental health wed on awareness and insight and use all their power to sustain it (20, 21). The pattern of marriage is among the factors whose role on mental health, marital commitment and family strength has been less studied. Unfortunately, in recent decades, we are facing an increase in the rate of divorce in Iran. In 2004, this rate was one divorce for every 9.8 marriages, while one divorce was registered for every 5.4 marriages in 2013 (19).

Nowadays, examining the role of commitment and mental health in marital relationships has become more important in family and marriage studies due to the rise in divorce rates because of factors such as infidelity. Therefore, the present study aimed to determine marital commitment and mental health in different patterns of mate selection in married women in Babol.

Materials and Methods

Methodology

This cross-sectional study was conducted in 2020 to assess marital commitment and mental health in different patterns of mate selection. The statistical population consisted of married women referring to selected urban and rural health centers in Babol. These centers were selected randomly from six regions of Babol city. Convenience sampling was employed in this study. Inclusion criteria include being married women and between 15-49 years of age, as well as living in Babol, lack of known psychological problems, and lack of severe mental disability. Participants were excluded from the study if they failed to answer at least 10% of the total questions of the questionnaire. Data obtained from 25 pilot samples were analyzed using PASS software, with mean $\mu1 = 51.17$, $\mu2 = 62.62$ and $\mu3 = 54.8$, $\sigma = 20.12$, power 80%, and error 0.05. The total sample size was estimated to be 160. A total of 160 volunteering subjects agreed to participate in our research and completed the questionnaires. The study protocol was explained to the subjects and informed consent was obtained from each person before enrolling in the study. Confidentiality and privacy of personal data were assured to participants.

Research Tools

Data collection tools included demographic characteristics, mate selection patterns, Adams and Jones Marital Commitment (DCI), and General Health Questionnaires (GHQ- 28).

1. A demographic characteristics questionnaire was used to collect demographic data such as age, marriage age, marriage duration, education level, place of birth, job, economic status, bearing the costs of living, and the number of children.
2. The Mate Selection Patterns Questionnaire consists of eight items designed by Behmanesh *et al.* (6) according to the instructions of a panel of experts and based on definitions of traditional and modern marriages in various sources (7). These eight items of the mate selection questionnaire were integrated based on the choice of couples either by themselves or their parents, friendship and interaction before marriage and satisfaction during marriage in the three patterns of traditional, modern and mixed marriage. To determine the items related to spouse selection patterns, a final questionnaire was designed by an expert panel and then the psychometric examination of the instrument was performed. Psychometrics of the instrument included steps to determine the quantitative and qualitative face and content validity. In order to evaluate quantitative content validity two content indexes were used: Content Validity Index (CVI) and Content Validity Ratio (CVR). To assess the reliability, the questionnaire was completed in two stages, two weeks apart, by 20 married women of reproductive age, and then the scores obtained in these two stages were compared using a correlation coefficient test (6).
3. The Marital Commitment Questionnaire (DCI) consists of 44 questions designed by Adams and Jones in 1997 and has three subscales: Commitment to Spouse, Commitment to Marriage, and Compulsory Commitment. This questionnaire measures the degree of adherence of people to their spouse and marriage, and its dimensions. The answers to the questions are ranked on a 5-point Likert scale (totally disagree, disagree, neither disagree nor agree, agree, and totally agree) with a score of 1 to 5. Total scores range from 1 to 172. A higher score means higher marital commitment (19). ShahSiah *et al.* (2009) obtained Cronbach's alpha for the subscales of personal commitment (66), Moral commitment (76), Structural commitment (78), and the total questionnaire (87) (15).
4. The General Health Questionnaire was a 28-item psychological questionnaire developed by Goldberg and Hiller (1979). It included four scales: physical symptoms, anxiety and sleep disturbance, social dysfunction, and depressive symptoms. Each scale had 7 questions. Scoring is based on a 4-point Likert system (0, 1, 2 and 3). Each person's score is between zero and 84. A higher overall score indicates more impairment in the individual's general health. In each scale, a score ≥ 6 and a total score ≥ 22 indicates pathological symptoms. The scale has been shown to have a Cronbach's alpha of 0.91 (19).

Data Analysis

All the data were analyzed by the SPSS software v. 25.0 (SPSS Inc., Chicago, Illinois, USA). Statistical analysis was done using analysis of variance (ANOVA), after confirmation of normality, and Chi-square test. Demographic variables were analyzed using descriptive statistics (mean and standard deviation for quantitative variables, and frequency and percentage for qualitative variables). Significance level is considered to be less than 0.05.

Ethical Considerations

The ethics committee of Babol University of Medical Sciences confirmed this protocol before starting the formal survey (ethical code: IR.MUBABOL.HRI.REC.1398.233).

Results

Demographics

The mean and standard deviation of the age of participants were 30.67 ± 6.42 years (17 to 48 years) and those of their husbands were 34.62 ± 6.98 years (22 to 55 years). Also, the mean age at marriage was 21.18 ± 3.64 years (13 to 30 years) and the mean duration of marriage was 9.48 ± 7.17 years (1 to 33 years). In terms of the level of education, 60.6% of the participants had a high school diploma and above, and 39.4% were undergraduate. These percentages were 67.5% (high

school diploma and above) and 32.5% (undergraduate) for the husbands, respectively.

Results of the mate Selection Patterns questionnaire, DCI and GHQ-28

In terms of mate selection, 51.2% of participants had used the mixed pattern, 28.8% the modern pattern and 20% the traditional pattern. The mean and standard deviation of married women's marital commitment were 162.42 ± 25.25, and in the marital commitment domains of commitment to spouse scale, commitment to marriage sale and feeling of commitment or compulsory commitment scale, they were 37.8 ± 5.99, 44.05 ± 7.13 and 80.57 ± 14.63, respectively. The mean and standard deviation of general health were 25.5 ± 9.82, and in the different dimensions of general health including physical symptoms sale, anxiety and sleep disorders scale, social functioning scale and depression scale it was 6.54 ± 3.39, 7.38 ± 4.22, 8.51 ± 3.81 and 3.04 ± 3.81, respectively.

The results of the present study showed that there was a statistically significant relationship between age and marriage patterns (P = 0.001). The mean age of married women in the traditional pattern (34.12 ± 6.79 years) was higher than in the combined (30.49 ± 5.87 years) and modern (28.61 ± 6.24 years) patterns. There was a statistically significant relationship between husband's age and marriage patterns (P = 0.002). The mean age of the spouse in the traditional pattern (37.62 ± 6.91 years) was higher than in the mixed (34.91 ± 6.59 years) and the modern (32.02 ± 6.89 years) patterns. The research data revealed that there is a statistically significant relationship between the duration of marriage and marriage patterns (P = 0.003). The mean duration of marriage in the traditional pattern (12.43 ± 8.72 years) was higher than in the mixed (9.78 ± 6.56 years) and the modern (6.91 ± 6.23 years) patterns. There was a statistically significant relationship between women's education and marriage patterns (P = 0.045). Those women with lower levels of education (under diploma) were more likely to marry with the traditional pattern (56.3%) than with the combined (39%) and modern (28.3%) patterns. There was a statistically significant relationship between the place of birth of women (P = 0.014) and their husbands (P = 0.047), and the marriage patterns. Among wives and husbands who lived in rural areas, the traditional pattern was more common (56.3% and 53.1% for the wife and husband respectively), as compared to the combined (36.6%, 47.6%) and modern (23.9%, 28.3%) patterns. There was a statistically significant relationship between husband's job and marriage patterns (P = 0.0001). The percentage of workers was higher in the traditional (28.1%) than the combined (8.5%) and the modern (4.3%) patterns. There is a statistically significant relationship between the number of children and marriage patterns (P = 0.020). The frequency of ≥ two children was higher in the traditional (43.8) than the combined (37.8) and the modern (19.6) patterns. Furthermore, marriage patterns had no statistically significant relationship (P > 0.05) with the husband's education level (P = 0.101), the woman's job (P = 0.556), family economic status (P = 0.366), bearing the costs of living (P = 0.270), and age at marriage (P = 0.233). The relationships between demographic characteristics and marriage patterns of married women are shown in Table 1.

Research data on the mean and standard deviation of the marital commitment score of married women were 154.12 ± 31.73 in the traditional, 164.79 ± 22.24 in the mixed, and 163.98 ± 24.64 in the modern marriage patterns. There was no statistically significant relationship between marital commitment and traditional, mixed and modern marriage patterns in married women (P = 0.113) and there was similar marital commitment in all three patterns of mate selection. The mean and standard deviation of commitment to the spouse among women who married with the traditional, combined and modern patterns were 35.75 ± 6.23, 38.26 ± 5.63 and 38.41 ± 6.27, respectively. Spouse commitment had no statistically significant relationship with traditional, mixed and modern marriage patterns among married women (P = 0.095). Thus, spouse commitment was similar in these three patterns of mate selection. The mean and standard deviation of the commitment to marriage of married women were 42.03 ± 8.95 in traditional marriage, 44.49 ± 6.43 in mixed marriage, and 44.67 ± 6.82 in modern marriage. The results show that there was no statistically significant relationship between the commitment to marriage and traditional, mixed and modern marriage patterns among married women (P = 0.200). Thus, there was a similar commitment to marriage in these three patterns of mate selection. The mean and standard deviation of the sense of commitment in the traditional marriage pattern were 76.34 ± 18.93, in combined marriage these were 82.05 ± 12.84 and in modern marriage these were 80.89 ± 13.99. There was no statistically significant relationship between the sense of commitment and the traditional, mixed and modern marriage patterns among married women (P = 0.172). Thus, those who had followed any of these three patterns of mate selection had a similar sense of commitment (Table 2).

The results showed that the mean and standard deviation of the mental health score of married women were 27.19 ± 11.25 in the traditional, 24.23 ± 8.52 in the mixed and 26.58 ± 10.79 in the modern marriage patterns. There was no statistically significant relationship between mental health and traditional, mixed and modern marriage patterns among married women (P = 0.239). The mean and standard deviation of the score of physical symptoms of married women were 6.96 ± 4.09 in the traditional, 6.24 ± 3.20 in the mixed and 6.76 ± 3.18 in the modern marriage patterns. There was no statistically significant relationship between physical symptoms and the traditional, mixed and modern marriage patterns among married women (P = 0.516). The mean and

standard deviation of the score of anxiety symptoms and sleep disorders of married women in the traditional marriage pattern were 7.78 ± 4.67, in mixed marriage these were 7.06 ± 4.04 and in modern marriage these were 7.67 ± 4.27. Anxiety symptoms and sleep disorders had no statistically significant relationship with the traditional, mixed and modern marriage patterns in married women (P = 0.616). The mean and standard deviation of the social functioning score of married women were 7.96 ± 3.01 in the traditional, 8.68 ± 3.01 in the mixed and 8.58 ± 3.89 in the modern marriage patterns. There was no statistically significant relationship between social performance and traditional, mixed and modern marriage patterns among married women (P = 0.661). The mean and standard deviation of the score of depressive symptoms of married women were 4.47 ± 5.19 in the traditional, 2.24 ± 2.53 in the mixed and 3.47 ± 4.28 in the modern marriage patterns. Depression score had a statistically significant relationship with traditional, mixed and modern marriage patterns in married women (P = 0.012). The mean score of depression was higher in the traditional pattern, as compared to the modern and mixed marriage patterns (Table 2).

Table 1. Relationship between Demographic Variables and Marriage Patterns of Married Women

Marriage pattern	Traditional		Mixed		Modern		F	P-value
Variable	M	SD	M	SD	M	SD		
Age(y)	34.12	6.79	30.49	5.87	28.61	6.24	7.625	0.001
Husband's age(y)	37.62	6.91	34.91	6.59	32.02	6.89	6.669	0.002
Age at marriage(y)	21.69	4.17	20.71	3.55	21.69	3.36	1.471	0.233
Marriage duration(y)	12.43	8.72	9.78	6.56	6.91	6.23	6.108	0.003
	N	%	N	%	N	%	$\chi 2$	P-value
Education level							6.202	0.045
> High school diploma	18	56.3	32	39.0	13	28.3		
≥ High school diploma	14	43.8	50	61.0	33	71.7		
Husband's Education level							4.584	0.101
> High school diploma	15	46.9	26	31.7	11	23.9		
≥ High school diploma	17	53.1	56	68.3	35	76.1		
Place of birth							8.484	0.014
Urban	14	43.8	52	63.4	35	76.1		
Rural	18	56.3	30	36.6	11	23.9		
Husband's place of birth							6.106	0.047
Urban	15	46.9	43	52.4	33	71.7		
Rural	17	53.1	39	47.6	13	28.3		
Job							3.014	0.556
Unemployed	15	46.9	42	51.2	24	52.2		
Working at home	6	18.8	12	14.6	3	6.5		
Working outdoors	11	34.4	28	34.1	19	41.3		
Husband's Job							24.544	0.0001
Unemployed	0	0.0	2	2.4	7	15.2		
worker	9	28.1	7	8.5	2	4.3		
Employee	10	31.3	36	43.9	23	50.0		
Self-employed	13	40.6	37	45.1	14	30.4		
Economic status of the family							8.720	0.366
Very weak	2	6.3	1	1.2	0	0		
Weak	5	15.6	5	6.1	6	13		
Medium	17	53.1	43	52.4	25	54.3		
Good	6	18.8	26	31.7	12	26.1		
Very good	2	6.3	7	8.5	3	6.5		
Bearing the costs of living								
Easy	1	3.1	6	7.3	4	8.7	0.581	0.270
Neither easy Nor hard	17	53.1	35	42.7	17	37		
Sometimes hard	7	21.9	27	32.9	21	45.7		
Hard	7	21.9	14	17.1	4	8.7		
Number of children							11.653	0.020
0	5	15.6	27	32.9	23	50		
1	13	40.6	24	29.3	14	30.4		
≥ 2	14	43.8	31	37.8	9	19.6		

Table 2. Comparison of Marital Commitment and General Health in Marriage Patterns of Married Women

Variable	Traditional		Mixed		Modern		F	P-value
	M	SD	M	SD	M	SD		
Marital Commitment	154.12	31.73	164.79	22.24	163.98	24.64	2.210	0.113
Commitment to Spouse	35.75	6.23	38.26	5.63	38.41	6.27	2.392	0.095
Commitment to Marriage	42.03	8.95	44.49	6.43	44.67	6.82	1.624	0.200
Compulsory Commitment	76.34	18.93	82.05	12.84	80.89	13.99	1.782	0.172
General Health	27.19	11.25	24.23	8.52	26.58	10.79	1.446	0.239
Physical symptoms	6.96	4.09	6.24	3.20	6.76	3.18	0.665	0.516
Anxiety and sleep disturbance	7.78	4.67	7.06	4.04	7.67	4.27	0.487	0.616
Social dysfunction	7.96	3.01	8.68	3.01	8.58	3.89	0.414	0.661
Depressive symptoms	4.47	5.19	2.24	2.53	3.47	4.28	4.454	0.012

Discussion

Results showed that there is no significant difference between marital commitments among women who married with various patterns of marriage. In other words, married women with traditional, mixed, and modern marriages have a similar marital commitment. Studies on marital commitment have reported conflicting results. Some investigations have shown that marital commitment decreases with true cognition after marriage and the loss of previous romantic relationships (1, 22). Sayar *et al.* have revealed that women who have married modernly take more advantage of family functioning. Therefore, modern marriage and acquaintance of couples before marriage can be effective in strengthening family functioning and increasing stability of the family foundation (23). In modern marriage, the endurance and stability of couples is higher due to deeper acquaintance of the parties before marriage (24). Asemi *et al.* showed that all three components of marital satisfaction, intimacy, and commitment are higher in traditional marriages than modern marriages (25), while in another study, it was shown that although intimacy and desire were higher in couples who had a modern marriage than those who married traditionally, the commitment component was not significantly different between the two groups (26). According to the results of a similar study, there was no significant difference in the commitment component between couples with traditional and non-traditional marriages, and despite the transition from traditional to non-traditional marriage, both groups emphasize the commitment component to some extent (8), which is consistent with findings of the present study.

One of the reasons why the present study found no significant differences in the marital commitment of women who married with various patterns is probably that our study population grew up in the same cultural and social environment and, despite the differences in their marriage patterns, had similar attitudes, beliefs, values and norms. A certain cultural and social environment creates common attitudes, beliefs, values and norms among members of a society, which probably justifies the absence of significant differences in marital commitment among married women with traditional, modern and mixed marriage patterns (27). It seems that the similarity of mean scores of marital commitment in the present study is a function of other factors influencing marital commitment, which requires further investigation in subsequent studies.

The data collected on commitment to spouse from married women with traditional, modern and mixed marriages did not show a significant difference. Commitment to the spouse was similar in women with different patterns of marriage. Other studies showed that there is a significant positive correlation between personal commitment of individuals and marital satisfaction, agreement and cohesion. The most important dimension of marital commitment is a pledge to the spouse, and other terms such as personal commitments have been introduced by researchers. Personal commitment means the interest and desire of a person to carry on with their married life based on marital satisfaction, and it has three subscales: attraction to the relationship, attraction to the spouse, and identity related to the relationship. Considering these factors, an individual remains committed and faithful to his or her marriage and is not forced to stay in this marriage by a social and moral duty (moral commitment), material factors, difficulty in ending the relationship or reactions of others (structural commitment). Individuals with a personal commitment to their marriage and spouse are attentive and interested (27, 28). In the present study, the absence of differences in the personal commitment component is probably due to lack of differences in the attitudes to marital life of women with various patterns of marriage, which has led to attraction to the husband and commitment to him regardless of external factors.

The results of the present study indicate that there is no significant difference between the three groups of married women, referring to selected urban and rural health centers in Babol, regarding commitment to marriage or moral obligation. Commitment to marriage or moral obligation is the second dimension of marital commitment based on religiosity and moral fidelity.

Three components are effective in moral commitment, including 1) The sanctity of the foundation of marriage; 2) Fidelity to the type of marital relationship that refers to one's values and moral principles (one can end their marriage or remain devoted to it based on their beliefs); and 3) A religious feeling about the spouse and marriage (27). The study by khodayarifard *et al.* also showed that there is a positive and significant relationship between religious attitude and marital satisfaction (29). The findings of the research by Shackleford *et al.* showed that people whose spouses had lower conscientiousness scores had lower satisfaction and more frequently experienced the breach of marital commitment (30). The research by Jarvis also showed that a high degree of conscientiousness and conscience can be a suitable factor predicting marital commitment in individuals (31). The absence of differences in the commitment to marriage or moral commitment in various patterns of marriage in the present study is probably due to a similar viewpoint on sanctity of the foundation of marriage, as well as fidelity to the type of marital relationship between different patterns of marriage resulting from living in the same cultural environment.

The findings of a recent study indicated that there is no significant difference between the degree of compulsion or structural commitment in various patterns of marriage among married women referring to selected urban and rural health centers in Babol. Structural commitment, which is the third dimension of marital pledge and, in many theories, is known as forced commitment, restraining forces, external pressure, and feeling trapped, refers to the obstacles and limitations that prevent leaving the marital relationship. It is the feeling of being forced to continue the relationship, which can be more important in our culture due to the existence of religious beliefs (28). The researchers concluded that the main predictors of structural commitment are marital satisfaction and religious beliefs (27). The findings of Mousavi's study also showed that there is a significant negative correlation between structural commitment and marital satisfaction, agreement and cohesion (28). A study by Godman *et al.* showed that there are certain religious beliefs and practices regarding how couples should approach each other as well as about the formation of marriage and that religious belief and marital and family life satisfaction are important factors predicting structural commitment (32). Religion promotes commitment in the individual and the institution of marriage, and religiosity provides a sacred purpose for marriage. Therefore, commitment to the relationship can be increased in couples by promoting and disseminating religious beliefs (33). Given the religious background of the city of Babol and the fact that religious values influence marital commitment, the absence of differences in structural commitment between women who married with various marriage patterns is partially justifiable.

Results showed that the average mental health in married women was slightly higher than normal and that traditional, mixed, or modern marriage patterns had no effect on increasing or decreasing mental health and its dimensions, namely physical symptoms, anxiety, sleep disorders, and social function. In this regard, the same study revealed that marriage is widely supposed to bear mental health benefits. Psychologists, epidemiologists, and sociologists have recently reported better physical and psychological health, longevity, and happiness in married individuals compared to those who have never been married (34). Furthermore, in a study entitled "marriage and mental health among young adults," Jeremy *et al.* found that married young adults display similar levels of psychological distress to young adults who are engaged in any type of romantic relationship and that there was no difference between them (35).

Our finding revealed a significant difference between different mate selection patterns in the depression score of the general health questionnaire. The depression dimension of mental health was significantly different in traditional, mixed and modern marriage patterns. Pairwise, ANOVA revealed that the mean depression score in traditional marriage was significantly higher than mixed marriage. Studies have shown that the method of choosing a spouse is critical to create satisfaction in married life as well as in family health. Therefore, friendships and premarital relationships are important in this regard (36). Choosing a spouse is the first and most important step in forming a family center, as the basis of the social system, the absence of which can lead to consequences including various personal and social harms such as depression and anxiety (4). The origin of many family problems lies in the mode a spouse is selected. In earlier times and in the traditional marriage pattern, marriage was a formal covenant to achieve a specific outcome (36). The man and woman got married with the consent of their families, but without prior knowledge of each other, and the demands of the youth may not have been heeded (4). Kizilhan revealed that women in forced marriages significantly suffer from mental health problems (37). Today, the parties have more important goals than marriage and intend to enjoy a lasting spiritual and physical relationship with their partner during their married life (36). In the combined model of marriage, despite the lack of interaction and friendship before marriage, there is satisfaction during marriage (6, 7), which can reduce many psychological consequences such as depression. Nevertheless, Aghaei *et al.* believed that in premarital friendships, the behavior of parties is artificial and meant to satisfy the other party, and their real behavior and character is manifested after marriage, which leads to the cooling of emotional relationships. In fact, a man and a woman come to a false acquaintance with a friend before marriage, losing the previous sincere relationship after marriage with a true acquaintance (38). It seems that the age of married women and duration of marriage are of

the possible factors influencing depression in traditional marriage compared to other patterns of marriage. In this regard, Fakhari *et al.* revealed that age, early marriage (younger than 18 years old) and negative life events, such as marital conflicts and loss of loved ones, are effective in leading to depression, especially among adults. Adults had the highest rate of depression compared to youth and adolescents (49.43%) (39). Since marriage is an inherent and natural need, it must be answered correctly, like other human requirements. Otherwise, it will have adverse effects both on the society and the individual (1).

Research data on the relationship between demographic variables and marriage patterns of married women revealed that the mean age of women, the mean age of their husbands, duration of marriage and the number of children were higher in the traditional model than in the combined and modern models. Women in the traditional model had lower levels of education than in other models, and the majority of their husbands were workers. Also, in most cases in the traditional pattern, the birthplace of the couples was the village. In this respect, Iran Mahboob and Mokhtari believe that the changing position of women in terms of education is among the factors that prompt them to reject traditional models. By adopting equal opportunities, women do not limit themselves to primary and secondary education. Thus, the woman is no longer confined to the home, waiting for a traditional marriage, marrying at a younger age, and accepting male domination (40). In fact, with the expansion of structural features of modernization such as urbanization, industrialization, education, geographical mobility and migration, as well as the development of modern values such as individualism, independence and autonomy of individuals, the new pattern of marriage has become more popular according to individual preferences and interests. The mentioned factors provide the opportunity of a wider range of choices for mate selection and, on the other hand, limit the prospect to control and monitor the family (41). Research shows that almost two-thirds of single young girls and boys like to choose their spouse directly out of love and affection, although they paid more attention to the opinion of their families in choosing a spouse when they grew older (41, 42).

Limitation

One of the limitations of this research is that the samples of the present study were women who referred to medical centers of Babol University of Medical Sciences. These people are different from other married women in the research community in terms of physical, mental and psychological characteristics as well as economic, social, cultural and occupational conditions. Therefore, generalization of the results of this research to other married people should be done with caution and its limitations must be considered. The sociocultural background has a great impact on the formation of a large part of people's behaviors, beliefs, attitudes and lifestyles. Considering the fact that the current project was conducted in the city of Babol, with its special sociocultural context, the culture of this group of people may not be in complete harmony with that of the other parts of the country and there may be differences. Hence, extending the results of this study to other parts of the country should be done cautiously. Finally, because factors such as marital conflicts and personality problems of couples may affect their commitment, the lack of control over these variables can be considered as a limitation of this project.

Conclusion

It seems that there is a kind of similar viewpoint among married women in Babol city, who married with different patterns, on marital commitment; although they had different mean scores of depression. Therefore, family planners should pay more attention to other factors that may affect the marital commitment and mental health of couples.

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Conflict of Interest

None.

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