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Comparing the Effectiveness of Acceptance and Commitment Therapy with Cognitive-Behavioral Therapy on Women's Relationship Obsessive-Compulsive Disorder

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A B S T R A C T

Objective: The aim of the present study was to compare the effectiveness of cognitive-behavioral therapy (CBT) and acceptance and commitment therapy (ACT) on relationship obsessive-compulsive disorder (ROCD) in women attending health centers.

Methods: The research design was applied in terms of aim and was a quasi-experimental study with a pretest-posttest design, two experimental groups, a control group, and a two-month follow-up period. The statistical population included all women referred to health centers and a private counseling center in Chalous city in 2023. Twenty participants were selected through convenience sampling and randomly assigned to two experimental groups and one control group. To collect data, the Relationship Obsessive-Compulsive Disorder Questionnaire by Doron et al. (2012) was used. For statistical analysis, SPSS-26 software, repeated measures ANOVA, and Bonferroni post hoc test were utilized.

Findings: The results indicated that CBT ($F=6.92$, $p<0.01$) and ACT ($F=6.97$, $p<0.01$) had a significant impact on ROCD scores over time ($p<0.01$), suggesting that both interventions significantly reduced ROCD in women attending health centers. A significant difference was found between pretest and posttest scores for ROCD in both approaches ($p<0.01$), indicating the meaningful effectiveness of these two therapeutic methods. No significant difference was observed between posttest and follow-up scores ($p>0.05$), indicating the stability of the effects.

Conclusion: Based on the findings, it can be concluded that both CBT and ACT can be used to reduce ROCD in women attending health centers, with no significant difference in the effectiveness of these therapeutic methods.

Keywords: *Cognitive-behavioral therapy, Acceptance and commitment therapy, Relationship obsessive-compulsive disorder, Women, Health centers.*

1. Introduction

Relationship Obsessive-Compulsive Disorder (ROCD) is a subtype of obsessive-compulsive disorder (OCD) that poses specific challenges for psychological interventions, especially cognitive-behavioral therapy (CBT), including sudden termination of treatment and relapse of symptoms (Doron et al., 2016; Doron et al., 2014; Doron et al., 2012). ROCD can manifest in various close relationships, such as parent-child, teacher-student, and even an individual's relationship with God. However, obsessive symptoms focusing on romantic relationships have recently garnered research attention (Tinella et al., 2023). Common manifestations of ROCD include doubts and preoccupations centered on one's suitability for their partner (e.g., the intensity of one's feelings towards their partner), the "rightness" of the relationship, and the perceived nature of the partner's feelings towards oneself. These symptoms are termed relationship-focused obsessive-compulsive symptoms (Gorelik et al., 2023).

ROCD can also include debilitating preoccupations about perceived flaws in one's partner (e.g., not being intelligent enough), known as partner-focused obsessive-compulsive symptoms (Kasalova et al., 2020). While similar to what is described in the literature as vicarious body dysmorphic disorder (focusing on others' physical defects) (Doron et al., 2014; Doron et al., 2012), partner-focused OCD symptoms refer to an obsessive preoccupation with a wide range of the partner's flawed characteristics (morality, sociability, success) (Sroosh et al., 2023). ROCD is essentially OCD with the content and nature of obsessions centered on the "relationship," a subject that has recently received significant research interest. Often, both clients and therapists are unaware of ROCD and its related phenomena, mistaking ROCD symptoms for life challenges or interpersonal problems. Concerns and doubts, particularly conflicts throughout the relationship, are common, and behaviors resembling ROCD may occur during the typical course of forming a relationship, especially in courtship, romantic encounters, or pre-commitment stages. Given these complexities, diagnosing ROCD can be challenging (Doron et al., 2014; Gorelik et al., 2023), highlighting the importance of finding suitable interventions to improve this disorder.

Various psychotherapeutic approaches have been used for different OCD types, proving their efficacy (Reid et al., 2021). One such approach is CBT, which focuses on modifying maladaptive thoughts and cognitive distortions, and altering behavioral patterns that cause distress. The goal of CBT is to enhance the individual's awareness of their thoughts, feelings, and experiences (Surmai & Duff, 2022). CBT promotes personal resilience through strategies that identify and challenge distorted thinking patterns (Leeuwerik et al., 2019). This approach provides opportunities for individuals to free themselves from rigid expectations and idealistic thoughts, accept their condition, and confront it rationally. Moreover, by changing cognitions and correcting irrational beliefs, individuals can transform their attitudes towards themselves, the world, and the future, adopting a new, flexible perspective instead of focusing on disabilities and hopelessness about the future (van Loenen et al., 2022).

Another therapeutic approach is Acceptance and Commitment Therapy (ACT). In ACT, the therapist aims to foster a value-based life, helping the client find and live in alignment with their values (Saadati et al., 2021). ACT, part of the third wave of cognitive-behavioral therapies, focuses on the individual's relationship with their internal experiences rather than the content of the experience itself (Gloster et al., 2020). ACT involves two hexaflexes: psychological flexibility and psychological inflexibility. Clients often experience psychological inflexibility, manifesting as rumination (past) and worry (future) rather than being present (Philip & Cherian, 2021). These individuals engage in experiential avoidance (actions to escape painful internal experiences, which decreases life quality), cognitive fusion (clinging to thoughts, judgments, and emotions), and excessive adherence to self-concept (influence of literal meanings constructed for oneself or others), leading to persistent inactivity or impulsivity and avoidance of valued actions (Thompson et al., 2021). ACT can be divided into acceptance (contact with the present moment, acceptance, defusion, and self-as-context) and commitment (value clarification and committed action). The hexaflex model is used for precise conceptualization based on three major philosophical and theoretical foundations: functional contextualism, relational frame theory, and applied behavior analysis (Ong et al., 2020). ACT aims to transition clients from psychological inflexibility to flexibility, fostering a rich and meaningful life while accepting the inevitable suffering (Saadati et al., 2021).

Given the necessity of providing effective psychotherapy services to women attending health centers, this study aimed to compare the effectiveness of CBT and ACT on ROCD in women attending health centers.

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2. Methods

2.1. Study design and Participant

The present study was applied in terms of its aim and utilized a quasi-experimental design with a pretest-posttest and follow-up with two experimental groups and one control group. The statistical population included all women attending health centers and a private counseling center in Chalous city in 2023. Twenty participants were selected through convenience sampling and randomly assigned to two experimental groups and one control group. Inclusion criteria included being female, not having severe psychological disorders, and not being addicted to drugs. Exclusion criteria included non-cooperation for more than two sessions and participation in other psychotherapy sessions outside of this study. The Relationship Obsessive-Compulsive Inventory (ROCI) by Doron et al. (2012) was used for data collection. Following sampling and random assignment to three groups (two experimental and one control), the pretest was administered. The experimental groups received their respective interventions, while the control group received no intervention. Posttests were administered after the intervention sessions, and follow-up tests were conducted after the follow-up period.

2.2. Measures

2.2.1. Relationship Obsessive-Compulsive Disorder

Developed by Doron et al. in 2012, this inventory consists of 12 items assessing three subscales: love for the partner (items 1, 7, 10, 14), relationship correctness (3, 5, 9, 12), and partner's love (4, 6, 11, 13), rated on a Likert scale from 0 (not at all) to 4 (very much). Items 2 and 8 are control questions. Doron et al. (2012) reported adequate internal consistency with correlation coefficients ranging from 0.66 to 0.92 ($p < 0.001$). ROCI subscales showed good correlations with the Obsessive-Compulsive Inventory-Revised (OCI-R) subscales ($p < 0.001$). Correlations with the Obsessive Beliefs Questionnaire (OBQ) ranged from 0.16 to 0.34; with the Depression, Anxiety, and Stress Scale (DAS), from 0.34 to 0.56; with the Experiences in Close Relationships (ECR) scale, from 0.24 to 0.36; and with the Relationship Assessment Scale (RAS), from -0.39 to -0.61, all significant at $p < 0.001$. Factor analysis revealed a good fit (CFI = 0.96, RMSEA = 0.089). The ROCI demonstrated good internal consistency and test-retest reliability, with Cronbach's alpha of 0.93 and significant correlations with related measures, confirming convergent validity. Ghomian et al. (2019) validated the ROCI in Iran with 459 married students from Tehran universities, reporting internal consistency from 0.66 to 0.89 ($p < 0.01$), test-retest reliability from 0.65 to 0.84, and Cronbach's alpha for the total scale of 0.88 and subscales from 0.74 to 0.79. Convergent and discriminant validity showed negative correlations with the Spanier Dyadic Adjustment Scale (DAS) from -0.27 to -0.56 ($p < 0.01$), and positive correlations with the DAS, Relationship Beliefs Inventory (RBI), Padua Inventory (PI-WSUR), and OCI-R from 0.26 to 0.61 ($p < 0.01$). Factor analysis confirmed good fit indices, indicating good validity and reliability (Shaeiri et al., 2019).

2.3. Measures

2.3.1. Cognitive-Behavioral Therapy

The therapy sessions were conducted based on Beck's (2020) guidelines, implemented in 8 group sessions of 60 to 75 minutes each (Farzin Bagheri et al., 2023; Gautam et al., 2020; Kathmann et al., 2022; Leeuwerik et al., 2019; Reid et al., 2021).

Session 1: Introduction and familiarization of members, review of the goals and expectations of the participants from the therapy, explanation of group rules, and the components and nature of anxiety. Homework: Reading the self-help book "Don't Be Afraid" (a guide to overcoming anxiety).

Session 2: Review of the previous session, evaluation of homework, teaching and discussing the cognitive model of thoughts and behavior, introduction, and identification of cognitive distortions along with the degree of belief in them. Homework: Completing the thought record sheet and reviewing cognitive distortions as homework.

Session 3: Review of the previous session, evaluation of homework and its barriers, review and discussion of strategies for combating cognitive distortions, and in-session practice. Homework: Practicing evidence examination using the thought record sheet as homework.

Session 4: Review of the previous session, evaluation of homework, psychoeducation: reviewing and discussing strategies to combat cognitive distortions (cost-benefit analysis) and practicing it in-session, summary, and conclusion. Homework: Practicing cost-benefit analysis using the thought record sheet as homework.

Session 5: Review of the previous session, evaluation of homework, identifying triggering situations, teaching the Subjective Units of Distress Scale (SUDS), social skills training, and role-playing. Homework: Preparing a hierarchy

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of anxiety-provoking situations with the percentage of induced feelings as homework.

Session 6: Review of the previous session, evaluation of homework, teaching mental imagery, imaginative and real exposure, assertiveness training, role-playing, summary, and practice reviewing social skills. Homework: Practicing mental review of social skills and completing thought record sheets.

Session 7: Review of the previous session, evaluation of homework, role-playing, and real exposure during the session (public speaking and presence in a group). Homework: Practicing real exposure and completing thought record sheets.

Session 8: Review of all sessions, evaluation of homework, real exposure discussion about factors contributing to relapse, and review of strategies to prevent relapse. Homework: Practicing and applying relapse prevention strategies.

2.3.2. Acceptance and Commitment Therapy

The ACT sessions were conducted based on the protocol by Hayes et al. (2005) in 8 group sessions of 60 minutes each (Asli azad et al., 2020; Gloster et al., 2020; Philip & Cherian, 2021; Saadati et al., 2021; Stockton et al., 2019; Taghavizade Ardakani et al., 2019; Wynne et al., 2019).

Session 1: Introduction of members, establishing a therapeutic relationship, conceptualizing the problem, familiarization with ACT concepts, and signing a cooperation and treatment contract.

Session 2: Exploration and evaluation of the patient's treatment methods and their effectiveness, discussing their temporary and limited effects, psychological acceptance, and value clarification and action.

Session 3: Helping the client recognize ineffective strategies and control, understanding their futility, and accepting painful personal experiences without struggle using metaphors, receiving feedback, and providing homework.

Session 4: Teaching emotion regulation, explaining the avoidance of painful experiences and its consequences, teaching acceptance steps, changing language concepts using metaphors, teaching relaxation techniques, receiving feedback, and providing homework.

Session 5: Discussing the interrelation of behavior, emotions, psychological functions, and observable behavior, and efforts to change behavior accordingly. Receiving feedback and providing homework.

Session 6: Explaining the concepts of role and context, viewing the self as a context, establishing contact with the self using metaphors, awareness of sensory perceptions, and distinguishing from mental content. Receiving feedback and providing homework.

Session 7: Explaining the concept of values, motivating change, empowering the client for a better life, and practicing mindfulness. Receiving feedback and providing homework.

Session 8: Teaching commitment to action, identifying behavioral plans aligned with values, committing to them, summarizing sessions, conducting post-tests, and teaching relaxation techniques using tension reduction methods for the follow-up phase.

2.4. Data Analysis

Data were analyzed using SPSS-26 software, repeated measures ANOVA, and the Bonferroni post hoc test.

3. Findings and Results

In terms of demographic characteristics, the mean (standard deviation) age of the cognitive-behavioral therapy group was 30.52 (5.41), the acceptance and commitment therapy group was 31.70 (5.91), and the control group was 30.13 (5.29). The descriptive data for all three groups at the pre-test, post-test, and follow-up stages are presented in Table 1.

Table 1

Descriptive Data of Scores for Experimental and Control Groups at Pre-test, Post-test, and Follow-up

Variable	Group	Pre-test Mean (SD)	Post-test Mean (SD)	Follow-up Mean (SD)
Relationship Obsessive-Compulsive	Cognitive-Behavioral Therapy	39.91 (4.41)	32.15 (5.50)	32.02 (5.56)
	Acceptance and Commitment Therapy	38.42 (4.30)	31.94 (4.81)	31.70 (4.91)
	Control	39.55 (4.88)	40.40 (5.32)	40.05 (5.17)

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As shown in Table 1, the scores for both experimental groups in relationship obsessive-compulsive disorder decreased significantly at the post-test stage, while the control group's scores did not change. To test the significance of the effectiveness of the training in both groups, repeated measures analysis of variance was used at three stages. For this purpose, the necessary assumptions must first be examined.

The results of the Shapiro-Wilk test showed that the data were normally distributed ($p > 0.05$). Additionally, the results of Levene's test confirmed the homogeneity of variances, and Mauchly's test confirmed the sphericity of the data ($p > 0.05$). Therefore, the use of mixed ANOVA with repeated measures at three stages is permitted.

Table 2

Mixed ANOVA with Repeated Measures at Three Stages

Source of Variation	Group	Components	Sum of Squares	df	Mean Square	F	Significance	Effect Size
Relationship Obsessive-Compulsive	Cognitive-Behavioral Therapy	Constant	20592.440	1	20592.440	230.59	0.000	0.94
		Group	671.207	1	671.207	6.92	0.003	0.36
		Error	927.855	19	48.83			
Relationship Obsessive-Compulsive	Acceptance and Commitment Therapy	Constant	21492.610	1	21492.610	255.66	0.000	0.95
		Group	704.117	1	704.117	6.97	0.003	0.37
		Error	915.320	19	48.17			

As shown in Table 2, cognitive-behavioral therapy ($F = 6.92$, $p < 0.01$) and acceptance and commitment therapy ($F = 6.97$, $p < 0.01$) had a significant impact on relationship obsessive-compulsive scores over time ($p < 0.01$), indicating that both interventions significantly reduced relationship obsessive-compulsive disorder in women attending health centers.

Table 3

Comparison of Adjusted Means for Experimental Groups

Variable	Stage 1	Stage 2	Cognitive-Behavioral Therapy	Significance	Acceptance and Commitment Therapy	Significance
Relationship Obsessive-Compulsive	Post-test	Pre-test	7.39	0.00	7.44	0.00
Relationship Obsessive-Compulsive	Follow-up	Pre-test	7.51	0.00	7.62	0.00
Relationship Obsessive-Compulsive	Follow-up	Post-test	0.33	1.00	0.30	1.00

According to the contents of Table 3, there was a significant difference between the pre-test and post-test scores for relationship obsessive-compulsive disorder in both approaches ($p < 0.01$), indicating the significant effectiveness of these two therapeutic methods. Furthermore, no significant difference was observed between the post-test and follow-up scores ($p > 0.05$), indicating that these effects were stable.

Table 4

Multiple Comparisons of Adjusted Means for Cognitive-Behavioral Therapy and Acceptance and Commitment Therapy Groups in Interaction of Group and Time (Pre-test and Post-test Stages)

Variable	Group I	Group J	Mean Difference (I-J)	Standard Deviation	Significance
Relationship Obsessive-Compulsive	Cognitive-Behavioral Therapy	Acceptance and Commitment Therapy	0.19	1.81	1.00

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According to Table 4, the analysis using the Bonferroni test shows that the difference in effectiveness between the two interventions on the research variables is not significant ($p > 0.05$).

4. Discussion and Conclusion

The aim of the present study was to compare the effectiveness of cognitive-behavioral therapy (CBT) and acceptance and commitment therapy (ACT) on relationship obsessive-compulsive disorder (ROCD) in women attending health centers. The results of the statistical analysis showed that although both therapeutic approaches were significantly effective, there was no significant difference in the effectiveness between CBT and ACT. Additionally, the results of the Bonferroni follow-up test showed that the effects of CBT and ACT were stable. The results of the present study are consistent with the findings of various other studies (Asli azad et al., 2020; Beck, 2020; Doron et al., 2016; Doron et al., 2014; Doron et al., 2012; Farzin Bagheri et al., 2023; Gautam et al., 2020; Gloster et al., 2020; González-Valero et al., 2019; Kathmann et al., 2022; Leeuwerik et al., 2019; Ong et al., 2020; Philip & Cherian, 2021; Reid et al., 2021; Saadati et al., 2021; Stockton et al., 2019; Surmai & Duff, 2022; Taghavizade Ardakani et al., 2019; Thompson et al., 2021; van Loenen et al., 2022; Wynne et al., 2019).

In explaining the findings, it can be said that this approach assumes that psychological distress arises from attempts to change uncomfortable internal experiences (i.e., thoughts and feelings), leading to maladaptive behavior. This escape from internal experience has emerged as a suitable transdiagnostic risk factor for targeting in prevention programs (Saadati et al., 2021). Acceptance and commitment therapy seeks to reduce ineffective control efforts and increase psychological awareness in the present moment (Philip & Cherian, 2021). In "acceptance and commitment therapy," clients are challenged to pay attention to what matters to them in various areas of life, such as work, family, intimate relationships, friendships, personal growth, health, spirituality, and the like. This therapy and its techniques encourage the observation and non-judgmental description of experiences in the present moment, which is referred to as "self-as-process." This experience helps clients to experience the world's changes as they are, not as the mind constructs them (Taghavizade Ardakani et al., 2019), which requires cognitive defusion and psychological acceptance. In fact, the ACT therapeutic program involves six core processes: acceptance, defusion, self-as-context, present moment awareness, values, and committed action, leading to psychological flexibility (Philip & Cherian, 2021). Each of these processes represents psychological skills that can be enhanced in any area of life in response to internal experiences or unwanted symptoms. Therefore, ACT is considered a transdiagnostic psychological intervention that potentially impacts various psychological symptoms and life issues (Stockton et al., 2019). ACT is based on principles that teach clients that attempts to avoid or control disturbing mental experiences are ineffective or counterproductive and exacerbate them. Clients are encouraged to fully accept these experiences (Gloster et al., 2020). Moreover, this approach emphasizes the individual's psychological awareness in the present moment, helping them become aware of their mental, physical, thoughts, feelings, and behaviors in the present moment. Then, they are taught to separate themselves from these mental experiences so that they can act independently of them (Thompson et al., 2021; Wynne et al., 2019). Subsequently, the focus is on reducing the excessive focus on the self-conceptualization of their life story constructed in their minds. Finally, clients are helped to recognize their personal values and translate them into specific behavioral goals, committing to actions directed towards those values while accepting their mental experiences (Gloster et al., 2020; Taghavizade Ardakani et al., 2019).

Additionally, one of the primary goals of cognitive-behavioral therapy is to eliminate errors, distortions, and biases in thinking so that individuals can function more effectively (Gautam et al., 2020). The cognitive-behavioral approach focuses on cognitive distortions and attempts to change emotions and behaviors, emphasizing behavior. The therapist helps clients identify their cognitive distortions and replace them with more positive and realistic thought patterns. Cognitive-behavioral therapy assumes that most psychological distress arises from negative cognitive distortions that are accepted uncritically and without conscious awareness (Beck, 2020). For treating these thoughts, clients must first become aware of their presence and influence, and then they are taught to create more positive and adaptive self-talk through cognitive restructuring (Kathmann et al., 2022; Leeuwerik et al., 2019; van Loenen et al., 2022). CBT is a strategic package consisting of elements such as increasing individuals' awareness, teaching relaxation and meditation, self-instruction training, cognitive restructuring, assertiveness training, enhancing social support networks, and anger

management (Surmai & Duff, 2022). This therapeutic method helps patients recognize their dysfunctional beliefs, misinterpretations, and cognitive distortions and realize that personal interpretations of life events cause behaviors and feelings. Overall, what they think is what they feel. Using CBT enables individuals to gain control and mastery, appropriately face various life problems or events, and learn to love themselves without criticism as they are (Gautam et al., 2020). Attention to CBT assumptions is based on changing cognition, emotion, and behavior, meaning that the CBT intervention in this study has helped participants correct their misconceptions about thoughts and emotions and use them to positively perceive their condition when relating to others. Moreover, by correcting beliefs and perceptions about their emotions, the groundwork for reducing negative emotions during the intervention was laid, making CBT effective in emotional regulation (Reid et al., 2021). In CBT, combining cognitive and behavioral strategies allows individuals to strive for serious behavioral changes and assess the outcomes. By changing thoughts and cognition, the therapeutic goal facilitates the transfer of learned skills to daily life, making the patient their own therapist, capable of better managing their emotions (Leeuwerik et al., 2019). Therefore, it seems logical that these two approaches would have a significant and equal effectiveness on relationship obsessive-compulsive disorder symptoms.

5. Suggestions and Limitations

This research, like all studies, faced limitations. One limitation was the use of self-report tools for data collection. If respondents answer these tools carelessly or without adhering to the principle of honesty, the findings can be erroneous. Additionally, some respondents may intentionally portray themselves better or worse than reality, which also causes errors. Another limitation was the use of a quasi-experimental design. This study had only one follow-up stage, which is insufficient to ensure the stability of the results. Moreover, there were intervening factors throughout the study that the researcher could not control. Finally, the use of convenience sampling can limit the generalizability of the findings. Therefore, caution must be exercised when generalizing the results of this study.

Based on the findings and the limitations of this study, the following suggestions are made: 1) It is recommended to compare the effectiveness of each treatment in this study with other psychotherapeutic approaches. 2) It is recommended to compare the effectiveness of the two approaches studied here on other variables and different statistical populations. 3) It is recommended to hold workshops to train counselors and psychologists in CBT and ACT. 4) Specialists are advised to use CBT and ACT for female clients.

Authors' Contributions

Authors contributed equally to this study.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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