KMAN PUBLISHING INSTITUTE
Journal Website

Article history:
Received 17 October 2025
Revised 28 January 2026
Accepted 03 February 2026
Initial Published 14 February 2026
Final Publication 01 May 2026

Applied Family Therapy Journal

Volume 7, Issue 3, pp 1-13

E-ISSN: 3041-8798

Comparison of the Effectiveness of Cognitive Behavioral Couple Therapy (CBT) and Intensive Short-Term Dynamic Psychotherapy for Couples (ISTDP) in Reducing Relationship Obsessive–Compulsive Disorder (ROCD) Symptoms and Improving Relationship Quality in Young Couples

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A r t i c l e I n f o

Article type:
Original Article

How to cite this article:
Hosseini, S. A. (2026). Comparison of the Effectiveness of Cognitive Behavioral Couple Therapy (CBT) and Intensive Short-Term Dynamic Psychotherapy for Couples (ISTDP) in Reducing Relationship Obsessive–Compulsive Disorder (ROCD) Symptoms and Improving Relationship Quality in Young Couples. *Applied Family Therapy Journal, 7*(3), 1-13.
http://dx.doi.org/10.61838/kman.aftj.4998

A B S T R A C T

Objective: This study aimed to compare the effectiveness of cognitive–behavioral couple therapy (CBT) and intensive short-term dynamic psychotherapy (ISTDP) in reducing relationship obsessive–compulsive disorder (ROCD) symptoms and improving relationship satisfaction among young couples.

Methods and Materials: The study was conducted as a randomized controlled clinical trial with a pretest–posttest design, a control group, and a three-month follow-up. The statistical population consisted of young couples seeking psychological services due to relationship difficulties. A total of 52 couples (104 individuals) who met the inclusion criteria were selected and randomly assigned to three groups: CBT (18 couples), ISTDP (17 couples), and a wait-list control group (17 couples). The interventions were delivered in ten weekly 90-minute couple-based sessions following standardized protocols. Data were collected using the Relationship Obsessive–Compulsive Inventory (ROCI) and the Couples Satisfaction Index (CSI), with general obsessive–compulsive symptoms (OCI-R) and negative emotional states (DASS-21) included as covariates. Data were analyzed using multivariate analysis of variance (MANOVA) and multivariate analysis of covariance (MANCOVA) in SPSS version 27.

Findings: MANOVA results indicated a significant multivariate effect of group on posttest ROCD symptoms and relationship satisfaction ($p < .001$), with large effect sizes. Univariate analyses showed significant between-group differences for both ROCD symptoms ($F(2,101) = 139.75$, $p < .001$) and relationship satisfaction ($F(2,101) = 282.32$, $p < .001$). Post hoc comparisons revealed that both CBT and ISTDP significantly outperformed the control group on both outcomes, while no substantial difference was observed between the two treatment groups in relationship satisfaction; ISTDP showed a marginally greater reduction in ROCD

symptoms. MANCOVA results confirmed that these effects remained robust after controlling for OCI-R and DASS-21 ($p < .001$).

Conclusion: Both CBT and ISTDP are highly effective couple-based interventions for reducing ROCD symptoms and enhancing relationship satisfaction, with comparable overall efficacy and strong clinical significance.

Keywords: *cognitive–behavioral couple therapy; intensive short-term dynamic psychotherapy; relationship obsessive–compulsive disorder; relationship quality; young couples*

1. Introduction

Intimate couple relationships constitute one of the most central contexts for adult psychological well-being, emotional regulation, and identity formation. Empirical evidence consistently demonstrates that relationship quality is closely associated with mental health outcomes, including anxiety, depression, stress regulation, and overall life satisfaction. Conversely, persistent relational distress and maladaptive interaction patterns are among the most robust predictors of psychological vulnerability and chronic interpersonal dysfunction. Contemporary models of couple therapy increasingly emphasize the bidirectional relationship between individual psychopathology and dyadic processes, underscoring the necessity of integrative therapeutic approaches that address both intrapersonal and interpersonal mechanisms (Doss et al., 2022; Fischer et al., 2016).

Among relationship-centered psychological phenomena, relationship obsessive–compulsive disorder (ROCD) has recently received growing empirical attention as a distinct manifestation of obsessive–compulsive pathology embedded within intimate relationships. ROCD is characterized by intrusive, distressing doubts and preoccupations concerning one's romantic partner, the correctness of the relationship, and one's own emotional responses within the relationship. These obsessions are commonly accompanied by compulsive behaviors such as reassurance seeking, comparison with others, emotional checking, and avoidance of intimacy, which paradoxically maintain and exacerbate relational distress. Unlike normative relational doubts, ROCD symptoms are persistent, ego-dystonic, and functionally impairing, often leading to significant deterioration in relationship satisfaction and emotional closeness (Ghomian et al., 2021; Tinella et al., 2023).

Theoretical and empirical models conceptualize ROCD as arising from the interaction between obsessive–compulsive vulnerability (e.g., intolerance of uncertainty, inflated responsibility, perfectionism) and attachment-related fears activated within close relationships. Research indicates that relationship duration, fear of guilt, and specific personality traits may modulate the expression and severity of ROCD symptoms, suggesting a complex interplay between dispositional factors and relational contexts (Tinella et al., 2023). Importantly, ROCD does not merely affect the individual experiencing obsessions; it disrupts dyadic regulation processes, increases conflict, and often pulls partners into maladaptive reassurance cycles, thereby transforming a primarily intrapersonal disorder into a relationally embedded psychopathology (Abramowitz et al., 2013; Gorelik et al., 2023).

Given the relational nature of ROCD, individual-focused interventions may be insufficient to address the full spectrum of maintaining mechanisms. In response, couple-based interventions—particularly those grounded in cognitive–behavioral principles—have been proposed as promising approaches. Couple-based cognitive–behavioral therapy (CBT) targets maladaptive cognitions, reassurance-seeking behaviors, avoidance patterns, and dysfunctional communication cycles that jointly maintain obsessive doubts and relationship dissatisfaction. Preliminary and controlled studies indicate that involving the partner in treatment can enhance outcomes by modifying interpersonal contingencies and reducing accommodation behaviors that reinforce obsessive–compulsive cycles (Abramowitz et al., 2013; Epstein & Zheng, 2017; Fischer et al., 2016).

CBT remains the most empirically supported psychological treatment for obsessive–compulsive disorder more broadly, with robust evidence supporting its efficacy across delivery formats, including face-to-face and internet-based modalities (Andersson et al., 2012; Spencer et al., 2023). Within couple contexts, CBT protocols emphasize cognitive restructuring of dysfunctional relationship beliefs, exposure with response prevention targeting reassurance and checking behaviors, and systematic training in communication and problem-solving skills. Recent innovations, including digital and mobile CBT-based interventions, further support the adaptability and scalability of CBT approaches for ROCD-related symptoms while

demonstrating positive effects on relationship resilience (Gorelik et al., 2023).

Despite the strong evidence base for CBT, there is increasing recognition that not all couples respond equally to cognitive–behavioral interventions. Some couples exhibit deep-seated emotional conflicts, defensive interaction patterns, and affective dysregulation that may limit the effectiveness of primarily cognitive or skills-based approaches. This recognition has renewed interest in psychodynamic models of couple intervention, particularly intensive short-term dynamic psychotherapy (ISTDP), which focuses on rapidly accessing unconscious emotional processes that underlie maladaptive relational patterns (Abbass et al., 2012; Davanloo, 2014).

ISTDP is an affect-focused, experiential psychodynamic approach grounded in Davanloo's model of unconscious anxiety regulation, defensive structures, and emotional conflict. Rather than targeting cognitions directly, ISTDP aims to dismantle maladaptive defenses, regulate anxiety, and facilitate direct emotional experiencing, thereby enabling corrective emotional processes within interpersonal relationships. Meta-analytic and outcome studies demonstrate that ISTDP is effective for a range of psychiatric conditions, including anxiety disorders, depression, personality pathology, and relational dysfunction, with evidence suggesting durable treatment effects (Abbass et al., 2012; Davanloo, 2014).

Emerging research has extended ISTDP to couple and relational contexts, suggesting that unresolved emotional conflicts and defensive patterns between partners may play a critical role in maintaining marital conflict, emotional manipulation, and relational dissatisfaction. Studies conducted in culturally diverse contexts, including Iranian samples, provide preliminary support for the effectiveness of short-term psychodynamic interventions in improving emotional differentiation, reducing maladaptive interpersonal behaviors, and enhancing relational functioning (Kashfi et al., 2024; Ranjbar Bahadari et al., 2022). These findings raise important questions regarding the comparative utility of CBT and ISTDP for couples experiencing ROCD-related distress.

Within the Iranian cultural context, couple relationships are embedded in strong normative expectations regarding emotional commitment, marital stability, and moral responsibility. Such expectations may intensify guilt, fear of making relational "mistakes," and perfectionistic standards within romantic relationships—factors that are theoretically and empirically linked to ROCD symptomatology (Ghomian et al., 2021; Tinella et al., 2023). Accordingly, culturally sensitive assessment tools and interventions are essential. The development of the Relationship Obsessive–Compulsive Inventory (ROCI) based on Iranian culture represents a significant advancement in this regard, enabling more accurate assessment of ROCD symptoms within local relational norms (Ghomian et al., 2021). Similarly, the validation of the Persian version of the Couples Satisfaction Index (CSI) provides a reliable measure for evaluating relationship quality in Iranian couples (Forouzesh Yekta et al., 2017).

Despite growing evidence supporting both CBT and ISTDP for relational and obsessive–compulsive phenomena, direct comparative studies examining their relative effectiveness for ROCD symptoms and relationship quality remain scarce. Existing research has often focused on either individual outcomes or general marital conflict, without systematically addressing the unique phenomenology of relationship-centered obsessions. Moreover, few studies have simultaneously evaluated symptom reduction and improvements in relationship satisfaction, despite evidence suggesting that these outcomes, while related, may follow distinct therapeutic trajectories (Doss et al., 2022; Fischer et al., 2016).

Recent applied studies in Iranian samples have demonstrated the effectiveness of CBT in improving marital relationship quality and psychological resilience among couples with relational conflict (Forouzani et al., 2024), as well as the utility of psychodynamic interventions in modifying sensation seeking, emotional manipulation, and relational instability (Kashfi et al., 2024; Ranjbar Bahadari et al., 2022). However, no randomized controlled study to date has directly compared CBT and ISTDP within a couple-based framework for ROCD symptoms while simultaneously controlling for general obsessive–compulsive severity and negative emotional states.

Methodologically rigorous comparison of these two approaches is critical for both theoretical and clinical reasons. From a theoretical perspective, such comparisons can clarify whether ROCD symptoms are more responsive to cognitive–behavioral mechanisms (e.g., belief modification, behavioral exposure) or to affective–dynamic mechanisms (e.g., defense restructuring, emotional processing). From a clinical perspective, identifying differential or comparable effectiveness can inform treatment selection, personalization, and stepped-care models for couples presenting with relationship-centered obsessions (Abbass et al., 2012; Epstein & Zheng, 2017).

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

Accordingly, the present randomized controlled study was designed to address these gaps by systematically comparing the effectiveness of cognitive–behavioral couple therapy and intensive short-term dynamic psychotherapy in reducing ROCD symptoms and improving relationship satisfaction among young couples, using culturally validated assessment tools and controlling for baseline obsessive–compulsive symptoms and negative emotional states, with the specific aim of determining whether CBT and ISTDP differ in their efficacy for reducing relationship obsessive–compulsive symptoms and enhancing relationship quality in young couples.

2. Methods and Materials

2.1. Study Design and Participants

The present study was conducted as a randomized clinical trial with a pretest–posttest design, including a control group and a follow-up phase. Within this framework, the effectiveness of two approaches—cognitive–behavioral couple therapy (CBT) and intensive short-term dynamic psychotherapy (ISTDP)—on marital conflict and cognitive flexibility in young couples was examined. Three groups were defined: a cognitive–behavioral couple therapy group (18 couples), an intensive short-term dynamic psychotherapy couple group (17 couples), and a control group (17 couples). Assessments were conducted at three time points (pretest, posttest, and three-month follow-up) to allow not only comparison of initial changes but also evaluation of the stability of intervention effects over time.

The study was implemented as a randomized clinical trial with a pretest–posttest design, a control group, and a three-month follow-up. The primary aim was to compare the effectiveness of cognitive–behavioral couple therapy (CBT) and intensive short-term dynamic psychotherapy (ISTDP) in reducing symptoms of relationship obsessive–compulsive disorder (ROCD) and improving relationship quality/satisfaction in young couples. Assessments were conducted at three time points: pretest (Week 0), posttest (end of the intervention period), and follow-up (three months after the end of the intervention).

The statistical population consisted of all couples who referred to a health–treatment center in Birjand City during the year of study implementation due to relationship problems, marital conflict, or dissatisfaction with relationship quality and sought psychological services. Inclusion criteria were: formal marriage (or a stable equivalent relationship) with at least one year of cohabitation; age within adulthood (20–45 years); presence of marital conflict or relationship dissatisfaction based on clinical assessment and a score above the cutoff point on the marital conflict questionnaire; and informed consent of both partners to participate in couple/group therapy and complete the questionnaires. Exclusion criteria included: diagnosis of severe psychiatric disorders (e.g., active psychotic disorders, bipolar disorder), active substance dependence, reports of severe and uncontrolled physical violence within the relationship, concurrent initiation of other intensive psychotherapeutic treatments during the intervention period, absence from more than two sessions, and unwillingness to continue cooperation with the researcher during the study process.

Sampling was conducted purposively/conveniently among eligible clients. Following initial screening and a structured clinical interview, 52 couples who met the inclusion and exclusion criteria were enrolled in the study. Couples were then randomly assigned to three groups: CBT (18 couples), ISTDP (17 couples), and control (17 couples). To ensure relative balance in baseline marital conflict severity across groups, random allocation was performed while considering pretest conflict scores (categorized into moderate and high levels).

In this study, implementation followed a coherent sequence of clinical and quantitative steps to ensure accurate diagnosis of obsessive–compulsive disorder with relationship-focused content (ROCD) and reliable evaluation of the effects of the two therapeutic approaches on symptoms and couple-related outcomes.

In the first step, after explaining the objectives and procedures of the study to couples referring to the health–treatment center and answering their questions, written informed consent was obtained from both partners. A demographic information form including age, duration of marriage, educational level, occupation, and treatment and psychiatric history was completed. It was emphasized that participation was voluntary, couples could withdraw at any time, and all information would be kept confidential.

In the second step, initial screening was conducted using a structured clinical interview by an experienced clinical psychologist to confirm inclusion criteria. This interview followed the SCID-5-CV guidelines (First et al., 2015) to identify relevant psychological disorders and assess the prominence of ROCD symptoms. Individuals deemed unsuitable for treatment or diagnosed with severe psychiatric disorders were excluded. Only couples in which one partner met OCD criteria with predominant ROCD content and both

partners demonstrated sufficient readiness and motivation for couple therapy were included in the final assessment.

After clinical eligibility was confirmed, participants completed a pretest battery of self-report instruments, including the Iranian version of the Relationship Obsessive–Compulsive Inventory (ROCI) to assess ROCD symptom severity, the Couples Satisfaction Index (CSI-32 or an appropriate short version) to evaluate relationship quality and satisfaction, and the Obsessive–Compulsive Inventory–Revised (OCI-R) and Depression, Anxiety, and Stress Scale (DASS-21) as auxiliary variables to control for overall obsessive severity and negative mood. This baseline assessment enabled pre-intervention group comparisons and statistical control of initial differences.

Subsequently, eligible couples were randomly assigned to one of three groups: cognitive–behavioral couple therapy (CBT; 18 couples), intensive short-term dynamic psychotherapy (ISTDP; 17 couples), and a control (wait-list) group (17 couples). Randomization was conducted using a random number table, with consideration of relative balance in baseline ROCD severity and relationship satisfaction to ensure comparable distribution of key variables across groups.

Following these steps, treatment implementation began. The treatment groups received couple-based interventions in ten weekly 90-minute sessions, whereas the control group received no active intervention during this period and only standard center services, with the ethical commitment that they would be offered one of the two treatments after completion of the follow-up period. Treatments were delivered by experienced therapists specializing in couple therapy. The therapeutic process in both groups strictly followed standardized and clearly specified protocols for each intervention:

– In the CBT group, cognitive restructuring and exposure to avoided responses (e.g., reassurance seeking and checking) were employed to reduce ROCD symptoms and enhance couples' communication skills.

– In the ISTDP group, emotion-focused psychodynamic interventions were applied, targeting the uncovering of unconscious emotions, removal of psychological defenses, and resolution of emotional conflicts within the context of couple relationships.

At the end of the ten-session intervention period, posttest assessments were conducted using the same battery of instruments (ROCI, CSI, OCI-R, and DASS-21) for all three groups to measure short-term treatment-related changes in ROCD symptoms, relationship satisfaction, and obsessive and mood indices. To evaluate the stability of treatment effects, a follow-up assessment was conducted three months after the end of the interventions, during which participants again completed the same questionnaires. This three-time-point design allowed simultaneous examination of immediate and sustained effects of the two couple therapy approaches on reducing relationship obsessive symptoms and improving relationship quality in young couples, while controlling for general changes in obsessive symptoms and mood through auxiliary variables.

2.2. Measures

1. Clinical Interview and Screening: In this study, to accurately assess relationship obsessive–compulsive disorder (ROCD) and couple-related outcomes, a set of validated clinical and self-report instruments was employed, each serving a specific role in identifying, measuring, and controlling primary variables and comorbidities. Accordingly, diagnosis of obsessive–compulsive disorder and determination of the prominence of relationship-focused obsessive content were first conducted using a structured clinical interview based on DSM-5 criteria, namely the Structured Clinical Interview for DSM-5 Disorders, Clinician Version (SCID-5-CV). This procedure ensured confirmation of OCD, selection of cases with predominant ROCD symptoms, and exclusion of individuals with severe disorders or conditions incompatible with participation in treatment.

2. Assessment of Relationship Obsessive–Compulsive Symptoms (ROCD): To specifically assess relationship obsessive symptoms, the Relationship Obsessive–Compulsive Inventory (ROCI) was used. This instrument evaluates three core domains of ROCD: doubts and preoccupations regarding the correctness of the relationship, the individual's feelings toward the partner, and perceptions of the partner's feelings toward the individual. The ROCI has been introduced and culturally adapted in Iranian studies by Ghomian et al. (2021), demonstrating satisfactory reliability and validity. This eight-item scale is brief, culturally appropriate for the Iranian context, and psychometrically sound. The Iranian culturally adapted version of the ROCI specifically assesses the three core ROCD domains within Iranian marital relationships, as reported in the original validation study (Ghomian et al., 2021).

3. Assessment of Relationship Quality: Relationship quality and satisfaction were assessed using the Couples

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

Satisfaction Index (CSI), specifically the CSI-32 form. The CSI-32 is a standard, change-sensitive instrument widely used in couple therapy research to measure overall relationship satisfaction and interaction quality, with high Cronbach's alpha and strong construct and convergent validity. In this study, the CSI-32 was used as the primary relational outcome at pretest, posttest, and follow-up to compare the effects of the two therapeutic approaches on relationship satisfaction and quality in young couples. The version proposed by Funk and Rogge (2007) demonstrates robust psychometric properties and includes a 32-item questionnaire to assess relationship satisfaction. The instrument contains one global item assessing overall happiness in the relationship on a 7-point scale (0 = extremely dissatisfied to 6 = excellent). The remaining 31 items are rated on a 6-point Likert scale; for example, the item "I feel that I can trust my spouse about almost anything." Psychometric findings indicate high correlations between the CSI and other validated marital satisfaction measures, supporting its strong convergent validity. Additionally, the questionnaire effectively discriminates distressed from non-distressed relationships. In an Iranian study by Forouzesh Yekta et al. (2017), Cronbach's alpha for the total scale was reported as 0.98, indicating excellent internal consistency (Forouzani et al., 2024).

4. Auxiliary/Control Variables: To control for the effects of comorbidities and the severity of negative affect, two measures were included as auxiliary/control variables: the Obsessive–Compulsive Inventory–Revised (OCI-R) for general obsessive–compulsive symptoms (Foa et al., 1998) and the Depression, Anxiety, and Stress Scale (DASS-21) for depression, anxiety, and stress (Lovibond & Lovibond, 1995). The OCI-R is the revised version of the Obsessive–Compulsive Inventory and consists of six subscales and 18 items rated on a 5-point Likert scale (0–4). The OCI-R subscales include washing, obsessions, hoarding, ordering, checking, and neutralizing. The OCI-R has demonstrated adequate internal consistency and test–retest reliability in multiple studies. The DASS-21 consists of 21 items assessing symptoms of negative emotional states (depression, anxiety, and stress). Lovibond and Lovibond (1995) reported Cronbach's alpha coefficients of 0.91, 0.81, and 0.89 for the depression, anxiety, and stress subscales, respectively, and showed that three-factor models provided a better fit to the data. In Iran, the three-factor structure of the DASS has also been confirmed (Asghari Moghaddam et al., 2008).

2.3. Interventions

CBT couple therapy protocol (Epstein & Zheng, 2017). The cognitive–behavioral couple therapy (CBT) intervention was delivered in ten weekly 90-minute sessions and followed a structured, skills-based protocol focused on modifying maladaptive relationship cognitions and reducing ROCD-maintaining behaviors. Core components included psychoeducation about ROCD mechanisms and the anxiety–reassurance cycle, identification and cognitive restructuring of dysfunctional appraisals (e.g., catastrophic interpretations of doubt, perfectionistic partner standards, intolerance of uncertainty), and systematic reduction of compulsive relational behaviors such as reassurance seeking, partner checking/monitoring, comparison, and repeated "testing" of feelings. Sessions also incorporated graduated exposure to triggering relational cues and response prevention (ERP) targeting avoidance and safety behaviors, alongside communication training (active listening, assertive expression, repair attempts) and problem-solving to improve dyadic interaction patterns. Homework assignments (thought records, behavioral experiments, exposure tasks, and planned communication practice) were used to consolidate gains and generalize skills to daily couple contexts.

ISTDP couple-based protocol (Abbass et al., 2012). The intensive short-term dynamic psychotherapy (ISTDP) intervention was likewise administered in ten weekly 90-minute sessions and emphasized affect-focused change through the rapid identification and restructuring of defensive processes that maintain relational distress and ROCD symptomatology. Treatment targeted unconscious emotional conflicts activated within the couple relationship by clarifying and challenging maladaptive defenses (e.g., intellectualization, distancing, projection, compulsive reassurance dynamics) and systematically increasing emotional experiencing and expression in-session. The therapist used pressure, clarification, and challenge to mobilize affect, tracked anxiety pathways (cognitive–perceptual disruption vs. somatic anxiety), and regulated arousal to keep emotional processing within an optimal therapeutic window. Interventions aimed to facilitate direct access to core emotions (e.g., anger, grief, guilt, longing) underlying obsessive doubts and repetitive checking, promote corrective emotional experiences between partners, and resolve attachment-related ruptures by fostering honest, regulated emotional communication. Between-session tasks emphasized observing defensive patterns and practicing

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

more authentic affective engagement within relationship interactions, consistent with ISTDP principles.

2.4. Data Analysis

Appropriate statistical tests were used to analyze the data and evaluate the effects of therapeutic interventions, with a specific focus on between-group changes across pretest, posttest, and follow-up. Preliminary analyses were first conducted to ensure that the assumptions required for valid statistical inference were met.

Prior to data analysis, the Shapiro–Wilk test was used to assess normality of the data. Levene's test was employed to examine homogeneity of variances across groups. Box's M test was also used to assess homogeneity of covariance matrices among groups.

Multivariate analyses of variance (MANOVA) and multivariate analyses of covariance (MANCOVA) were used to analyze the data. These analyses examined changes in ROCD symptoms (using the ROCI) and relationship quality (using the CSI-32) across the three main groups. The analyses focused on comparisons of group means with respect to time effects (pretest–posttest and posttest–follow-up) and group effects (CBT, ISTDP, and control) and were conducted using SPSS version 27.

Post hoc tests were conducted to identify between-group differences and examine treatment effects within each group. Partial eta squared (η^2) was calculated to assess effect sizes for the time × group interaction and evaluate the practical significance of the interventions. Additionally, Bonferroni-adjusted post hoc comparisons were used to analyze differences in relationship quality indices and ROCD symptoms.

To ensure accuracy and stability of measurement, the internal consistency of the instruments was examined by calculating Cronbach's alpha coefficients using data obtained from the present sample. The results indicated that all questionnaires—the Relationship Obsessive–Compulsive Inventory (ROCI), the Couples Satisfaction Index (CSI), the Obsessive–Compulsive Inventory–Revised (OCI-R), and the Depression, Anxiety, and Stress Scale (DASS-21)—demonstrated acceptable reliability, with Cronbach's alpha coefficients exceeding the accepted threshold ($\alpha \geq 0.70$). Accordingly, the data derived from these instruments were considered reliable and suitable for subsequent statistical analyses and interpretation of results.

3. Findings and Results

Prior to conducting inferential tests to compare the groups, the normality of data distribution was examined using the Kolmogorov–Smirnov and Shapiro–Wilk tests. The results indicated that, for all variables, the significance levels of the tests were greater than the threshold value of 0.05; therefore, no significant deviation from the normal distribution was observed. Accordingly, the distribution of the data in the three study groups (cognitive–behavioral therapy, intensive short-term dynamic psychotherapy, and control) was normal. Thus, the use of parametric tests to compare group means was considered conceptually and statistically appropriate.

Table 1

Descriptive statistics of ROCI and CSI in the experimental and control groups (pretest–posttest)

Variable	Group	N	Pretest (M ± SD)	Posttest (M ± SD)
ROCD symptoms (ROCI)	CBT	18	29.22 ± 1.588	23.50 ± 1.183
	ISTDP	17	28.85 ± 1.743	22.74 ± 1.189
	Control	17	28.62 ± 1.557	27.56 ± 1.460
Relationship satisfaction (CSI)	CBT	18	51.22 ± 2.870	63.28 ± 3.113
	ISTDP	17	50.09 ± 2.633	63.03 ± 2.611
	Control	17	49.38 ± 1.776	50.38 ± 1.776

Based on the statistical results presented in Table 1, the pattern of mean changes indicates notable differences between the experimental and control groups from pretest to posttest. For relationship-focused obsessive symptoms (ROCI), both the CBT and ISTDP groups demonstrated a marked reduction in posttest mean scores compared with pretest scores, whereas the control group showed only a minimal decrease with no meaningful change. Similarly, for relationship satisfaction (CSI), posttest mean scores in both treatment groups increased substantially relative to pretest scores, while the control group experienced only negligible change. In addition, comparison of posttest means between the CBT and ISTDP groups reveals very close values, with no apparent descriptive-level difference. This descriptive

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

pattern, while confirming the overall effectiveness of the therapeutic interventions compared with no intervention, indicates that to more precisely examine between-group differences and control for pretest scores, the application of multivariate inferential analyses—such as MANOVA and MANCOVA—is both necessary and justified.

In the subsequent inferential analyses of this study, a MANOVA was first conducted to determine whether treatment type produced a statistically significant difference in the pattern of relational variables. Next, to examine the durability of treatment effects while statistically controlling for two covariates—general obsessive–compulsive symptoms (OCI-R) and negative emotional states (DASS-21)—a multivariate analysis of covariance (MANCOVA) was performed. These analytic steps increase the precision of testing the primary hypothesis and prevent confounding of treatment outcomes by underlying psychological factors, thereby substantially strengthening the internal validity of the findings from both methodological and clinical perspectives.

Table 2

Multivariate Tests of Group Effects on ROCD Symptoms and Relationship Satisfaction (CSI)

Effect	Test Statistic	Value	F	Hypothesis df	Error df	Sig.	Partial η^2
Group	Pillai's Trace	1.007	51.208*	4.000	202.000	< .001	0.50

The multivariate MANOVA results (Table 2) confirmed a strong and statistically significant effect of treatment group on the combined dependent variables, including posttest ROCD symptoms (ROCI_post) and posttest relationship satisfaction (CSI_post). These findings indicate substantial differences among the three study groups (CBT, ISTDP, and control) in treatment outcomes. The large effect size (ηp^2 = 0.50) suggests that approximately 50% of the variance in posttest outcomes is explained by group membership and treatment type. Accordingly, the prerequisite for proceeding to univariate analyses was met, and the univariate tests were subsequently examined to determine the unique contribution of each dependent variable, as presented in Table 3.

Table 3

Univariate Tests for the Effect of Group on Dependent Variables (Posttest)

Dependent Variable	Source	Sum of Squares	df	Mean Square	F	Sig.	Partial η^2
Post_ROCI	Group	459.385	2	229.692	139.753	< .001	.735
	Error	166.000	101	1.644			
Post_CSI	Group	3735.739	2	1867.870	282.323	< .001	.848
	Error	668.222	101	6.616			

R^2 = .735 for Post_ROCI (Adjusted R^2 = .729); R^2 = .848 for Post_CSI (Adjusted R^2 = .845).

Univariate results showed that the main effect of group was statistically significant for both dependent variables at posttest. Specifically, there was a significant difference among the CBT couple therapy group, the ISTDP couple therapy group, and the control group in relationship-focused obsessive symptoms ($F(2,101) = 139.75$, $p < .001$, $\eta p^2 = .735$), indicating a very large intervention effect in reducing ROCD symptoms. Likewise, the effect of group on relationship satisfaction was significant and strong ($F(2,101) = 282.32$, $p < .001$, $\eta p^2 = .848$), such that a large proportion of variance in relationship satisfaction was explained by treatment type. These findings indicate that, relative to the control group, the therapeutic interventions produced substantial improvements in relational outcomes. Given the significance of the overall group effect, post hoc tests were required to clarify the specific pattern of between-group differences and identify which groups differed significantly.

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

Table 4

Bonferroni Posttest Pairwise Comparisons for Study Variables

Dependent Variable	(I) Group	(J) Group	Mean Difference (I–J)	Std. Error	Sig.	95% CI Lower	95% CI Upper
Post_ROCI	CBT	ISTDP	.76*	.307	.043	.02	1.51
	CBT	Control	-4.06*	.307	.000	-4.81	-3.31
	ISTDP	CBT	-.76*	.307	.043	-1.51	-.02
	ISTDP	Control	-4.82*	.311	.000	-5.58	-4.07
	Control	CBT	4.06*	.307	.000	3.31	4.81
	Control	ISTDP	4.82*	.311	.000	4.07	5.58
Post_CSI	CBT	ISTDP	.25	.615	1.000	-1.25	1.75
	CBT	Control	12.90*	.615	.000	11.40	14.39
	ISTDP	CBT	-.25	.615	1.000	-1.75	1.25
	ISTDP	Control	12.65*	.624	.000	11.13	14.17
	Control	CBT	-12.90*	.615	.000	-14.39	-11.40
	Control	ISTDP	-12.65*	.624	.000	-14.17	-11.13

Bonferroni post hoc results for relationship obsessive symptoms (ROCI) indicated that the ISTDP group showed a small but statistically significant greater reduction in ROCD symptoms compared with the CBT group (MD = −0.76, SE = 0.307, p = .043, 95% CI [−1.51, −0.02]). However, both treatment groups exhibited highly significant reductions in ROCD symptoms relative to the control group (CBT vs. control: MD = −4.06, p < .001; ISTDP vs. control: MD = −4.82, p < .001). These findings support the strong efficacy of both interventions in reducing relationship obsessive symptoms, while the advantage of ISTDP over CBT appears small and near the threshold of significance. Similarly, pairwise comparisons for relationship satisfaction (CSI) indicated no statistically significant difference between the CBT and ISTDP groups (MD = 0.25, SE = 0.615, p = 1.000), suggesting comparable effectiveness of the two approaches. In contrast, both treatment groups demonstrated significant increases in relationship satisfaction compared with the control group.

Overall, this pattern indicates that both cognitive–behavioral couple therapy and intensive short-term dynamic psychotherapy were significantly and almost equally effective, relative to the control group, in improving relationship satisfaction (approximately a 13-point increase) and reducing relationship obsessive symptoms (approximately a 4–5 point reduction). The observed difference favoring ISTDP in ROCD symptoms appears clinically limited and does not provide evidence for a decisive superiority of either approach.

After establishing differences among the three groups (CBT, ISTDP, and control), a MANCOVA was conducted to examine the net effects of the interventions while controlling for comorbidity-related variables. Specifically, the analysis tested whether group differences remained statistically significant after controlling for baseline general obsessive–compulsive symptoms (OCI-R) and negative emotional states (DASS-21). The results are presented below.

Table 5

Multivariate Tests of Group Effects (MANCOVA)

Test	Value	F	Hypothesis df	Error df	Sig.	Partial η²
Pillai's Trace	1.334	99.214	4	198	< .001	.667
Wilks' Lambda	.012	404.805	4	196	< .001	.892
Hotelling's Trace	55.099	1336.161	4	194	< .001	.965
Roy's Largest Root	54.556	2700.498	2	99	< .001	.982

N = 104 (CBT: n = 36, ISTDP: n = 34, Control: n = 34). Covariates entered: pretest OCI-R and pretest DASS-21.

The MANCOVA results, controlling for pretest general obsessive–compulsive symptoms (OCI-R) and psychological distress/negative affect (DASS), showed that the effect of group on the combined dependent variables (ROCI and CSI) remained highly significant and strong. Pillai's Trace (1.334), F(4,198) = 99.214, p < .001, with a large effect size (Partial η^2 = .667), indicates that even after removing baseline differences, the interventions continued to produce significant group differences. This large effect suggests that approximately 67% of the shared variance in

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

posttest outcomes can be attributed to treatment group membership. Convergence across the four multivariate statistics (Pillai, Wilks, Hotelling, and Roy), all with very large effect sizes (η^2 ranging from .67 to .98), further indicates the robustness and stability of the results.

Table 6

Tests of Between-Subjects Effects (Adjusted Means)

Dependent Variable	Source	F	Sig.	Partial η^2
Post-ROCI	Group	1118.631	< .001	.958
	OCI-R	0.166	.685	.002
	DASS	46.461	< .001	.319
Post-CSI	Group	2062.867	< .001	.977
	OCI-R	39.425	< .001	.285
	DASS	0.422	.518	.004

At the univariate level, the effect of group remained very strong and statistically significant for both posttest outcomes. For relationship obsessive symptoms, the group effect was $F(2,99) = 1118.63$ with an extremely large effect size (Partial $\eta^2 = .958$); in this outcome, only baseline negative emotional states (DASS) showed a statistically significant covariate effect (Partial $\eta^2 = .319$), whereas baseline general obsessive–compulsive symptoms (OCI-R) did not. By contrast, for relationship satisfaction, the group effect was even stronger ($F(2,99) = 2062.87$, Partial $\eta^2 = .977$), and baseline OCI-R emerged as a significant covariate (Partial $\eta^2 = .285$), whereas baseline DASS did not contribute significantly.

Overall, this pattern suggests that both cognitive–behavioral couple therapy and intensive short-term dynamic psychotherapy, after controlling for baseline obsessive symptoms and negative emotional states, demonstrate comparable effectiveness in improving relationship quality and show clear superiority over the control group in reducing ROCD symptoms. The very large effect sizes indicate high clinical importance, rather than merely statistical significance, and they corroborate the initial MANOVA findings with greater precision and statistical power.

4. Discussion

The present study aimed to compare the effectiveness of cognitive–behavioral couple therapy (CBT) and intensive short-term dynamic psychotherapy (ISTDP) in reducing relationship obsessive–compulsive disorder (ROCD) symptoms and improving relationship satisfaction among young couples. The findings demonstrated that both therapeutic approaches produced significant reductions in ROCD symptoms and substantial improvements in relationship satisfaction compared with the control group. Moreover, the multivariate analyses revealed very large effect sizes for both outcomes, indicating not only statistical significance but also strong clinical relevance. Importantly, although ISTDP showed a marginal advantage over CBT in reducing ROCD symptoms at the posttest level, the magnitude of this difference was small, and both interventions exhibited comparable effectiveness in enhancing relationship satisfaction.

The significant reduction in ROCD symptoms observed in both treatment groups aligns with contemporary theoretical models that conceptualize ROCD as a disorder maintained by maladaptive cognitive–emotional processes embedded within intimate relationships. From a CBT perspective, the observed symptom reduction can be attributed to systematic targeting of dysfunctional beliefs about relationships, intolerance of uncertainty, and reassurance-seeking behaviors that perpetuate obsessive doubts. Previous studies have shown that couple-based CBT interventions effectively reduce obsessive–compulsive symptoms by disrupting maladaptive interpersonal reinforcement cycles and reducing partner accommodation (Abramowitz et al., 2013; Epstein & Zheng, 2017; Fischer et al., 2016). The present findings extend this evidence by demonstrating that CBT remains effective when ROCD symptoms are assessed using a culturally adapted measure and when outcomes are evaluated within a randomized controlled design.

Similarly, the effectiveness of ISTDP in reducing ROCD symptoms is consistent with psychodynamic conceptualizations that emphasize unresolved emotional conflicts, defensive processes, and anxiety dysregulation as core maintaining mechanisms of obsessive symptomatology. ISTDP's focus on rapidly identifying and dismantling maladaptive defenses may have enabled participants to experience and process underlying

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

emotions—such as guilt, anger, or fear of relational loss—that often manifest phenomenologically as obsessive doubts. Meta-analytic evidence supports the efficacy of ISTDP across a range of anxiety and relational disorders, highlighting its capacity to produce durable symptom change through affective restructuring (Abbass et al., 2012; Davanloo, 2014). The present study contributes to this literature by demonstrating that ISTDP is also effective in a couple-based format for ROCD-related symptoms.

The marginally greater reduction in ROCD symptoms observed in the ISTDP group relative to CBT, while statistically significant, should be interpreted cautiously. The small effect size suggests that this difference may reflect variations in therapeutic emphasis rather than a clear superiority of one approach. It is plausible that ISTDP's direct focus on unconscious emotional conflict provided incremental benefits for participants whose obsessive doubts were closely tied to unresolved affective experiences within the relationship. This interpretation is consistent with prior findings indicating that psychodynamic interventions can be particularly effective for individuals with complex emotional and relational dynamics (Kashfi et al., 2024; Ranjbar Bahadari et al., 2022). Nevertheless, the absence of a robust difference between the two treatments suggests that both approaches are viable options for addressing ROCD in couple contexts.

In terms of relationship satisfaction, both CBT and ISTDP produced large and nearly identical improvements compared with the control group. This finding underscores the importance of directly addressing dyadic processes when treating relationship-centered psychopathology. CBT likely improved relationship satisfaction by enhancing communication skills, reducing conflict escalation, and fostering more adaptive problem-solving patterns between partners. Extensive evidence supports the efficacy of CBT-based couple therapies for improving relationship quality across diverse populations and presenting problems (Doss et al., 2022; Fischer et al., 2016). The present results are consistent with studies conducted in Iranian samples demonstrating that CBT can significantly enhance marital relationship quality and psychological resilience among couples experiencing conflict (Forouzani et al., 2024).

At the same time, ISTDP's effectiveness in improving relationship satisfaction suggests that affect-focused interventions can also produce meaningful dyadic change. By facilitating emotional openness, reducing defensive interactions, and promoting corrective emotional experiences between partners, ISTDP may enhance intimacy and mutual understanding—key components of relationship satisfaction. Prior psychodynamic research has documented improvements in relational functioning following short-term dynamic interventions, particularly in populations characterized by emotional suppression or maladaptive interpersonal patterns (Abbass et al., 2012; Davanloo, 2014). The current findings provide further empirical support for the application of ISTDP in couple therapy contexts.

The multivariate covariance analyses further strengthened the conclusions by demonstrating that treatment effects remained robust even after controlling for general obsessive–compulsive symptoms and negative emotional states. This finding indicates that the observed improvements were not merely a byproduct of reductions in overall distress or baseline obsessive severity but reflected specific therapeutic effects on relationship-centered symptoms and satisfaction. Notably, general negative affect was a significant covariate for ROCD symptoms but not for relationship satisfaction, whereas baseline obsessive severity was more strongly associated with relationship satisfaction outcomes. This pattern suggests that while emotional distress may exacerbate obsessive doubts, relationship satisfaction is more directly influenced by relational and cognitive factors—a distinction that aligns with prior theoretical models (Gorelik et al., 2023; Tinella et al., 2023).

From a broader clinical perspective, the comparable effectiveness of CBT and ISTDP highlights the value of maintaining multiple evidence-based options for couples presenting with ROCD. CBT's structured, skills-oriented framework may be particularly suitable for couples who prefer directive interventions and clear behavioral strategies, whereas ISTDP may be advantageous for couples with entrenched emotional conflicts or limited emotional awareness. This complementarity echoes recommendations in the couple therapy literature emphasizing the importance of treatment matching and flexibility rather than a one-size-fits-all approach (Doss et al., 2022; Epstein & Zheng, 2017).

The findings also have implications for culturally informed practice. The use of culturally adapted assessment tools, such as the Iranian version of the ROCI and CSI, enhances confidence that observed effects reflect meaningful change within the participants' sociocultural context (Forouzesh Yekta et al., 2017; Ghomian et al., 2021). Given the strong cultural emphasis on marital stability and moral responsibility in Iranian society, interventions that effectively reduce relational doubt and enhance satisfaction may have particularly significant psychosocial benefits.

AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798

5. Conclusion

Overall, the present study contributes to the growing literature on ROCD by providing one of the first randomized controlled comparisons of CBT and ISTDP in a couple-based format. The results suggest that both approaches are highly effective in reducing ROCD symptoms and improving relationship satisfaction, with no clear evidence of decisive superiority for either intervention. These findings support integrative and flexible treatment planning and underscore the importance of addressing both cognitive–behavioral and emotional–dynamic mechanisms in the treatment of relationship-centered obsessive–compulsive phenomena.

6. Limitations & Suggestions

Despite its strengths, the present study has several limitations that should be considered when interpreting the findings. First, the sample size, although adequate for detecting large effects, limits the generalizability of the results to broader populations and may have reduced sensitivity to detect smaller differences between treatment approaches. Second, reliance on self-report measures may introduce response biases, particularly in the assessment of relationship satisfaction. Third, the follow-up period was relatively short, restricting conclusions about the long-term durability of treatment effects. Finally, therapist effects and treatment fidelity were not formally assessed, which may have influenced outcomes.

Future studies should aim to replicate these findings with larger and more diverse samples, including couples from different age groups, cultural backgrounds, and relationship stages. Longer follow-up periods are needed to evaluate the stability of treatment gains over time. Additionally, future research could examine potential moderators and mediators of treatment response, such as attachment styles, emotion regulation capacities, or levels of partner accommodation. Incorporating qualitative methods may also provide deeper insight into couples' subjective experiences of change across different therapeutic approaches.

Clinicians working with couples experiencing ROCD symptoms may consider both CBT and ISTDP as effective intervention options, selecting approaches based on couples' preferences, emotional readiness, and relational dynamics. Integrating elements from both models—such as combining cognitive restructuring and exposure with affect-focused emotional processing—may further enhance outcomes. Training programs for couple therapists should emphasize flexibility and competence in multiple evidence-based modalities. Finally, routine assessment of relationship-centered obsessive symptoms and relationship satisfaction can help guide treatment planning and monitor progress throughout therapy.

Acknowledgments

We would like to express our appreciation and gratitude to all those who cooperated in carrying out this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

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

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

Funding

This research was carried out independently with personal funding and without the financial support of any governmental or private institution or organization.

Authors' Contributions

All authors have contributed significantly to the research process and the development of the manuscript.

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.

Acknowledgments

We would like to express our gratitude to all individuals helped us to do the project.

Declaration of Interest

The authors report no conflict of interest.

Funding

This research was carried out independently with personal funding and without the financial support of any governmental or private institution or organization.

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AFTJ Applied Family Therapy Journal
E-ISSN: 3041-8798