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Comparison of the effectiveness of the schema therapy package based on psychosocial issues of obsessive-compulsive patients with cognitive-behavioral therapy on early maladaptive schemas and anxiety in patients with obsessive-compulsive disorder

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ABSTRACT

Background and Aim: obsessive-compulsive disorder is a debilitating anxiety disorder whose main feature is the occurrence of obsessions and compulsive actions. The purpose of this study is to compare the effectiveness of the schema therapy package based on psycho-social issues of obsessive-compulsive patients with cognitive-behavioral therapy on early maladaptive schemas and anxiety in patients with obsessive-compulsive disorder. **Methods:** This article was a semi-experimental method, pre-test-post-test type with a control group and a 45-day follow-up period. The research population in this study included all patients with obsessive-compulsive disorder who referred to two psychotherapy clinics in Isfahan city. For the study, 45 people were randomly selected into two groups of schema therapy based on psychosocial issues (based on Young, Kliusko and Wishar, 2003), cognitive-behavioral therapy (Struch et al., 2007) and a control group (each group). 15 people) were placed. Before and after the intervention and 45 days later (follow-up stage), the subjects responded to the short-form Young's schema questionnaire (Young, 1994) and the anxiety questionnaire (Beck, 1989). The data was analyzed using the method of analysis of variance with repeated measurements and Spss.22 software. **Results:** The results of the study showed that there is a significant difference in the mean of early maladaptive schemas and anxiety in two experimental groups (schema therapy and cognitive-behavioral therapy) and evidence. In addition, based on the results of schema therapy compared to cognitive-behavioral therapy, in the reduction of early maladaptive schemas ($F=33.06$; $P<0.001$) and anxiety ($F=11.26$; $P<0.001$) Patients were more effective. **Conclusion:** Compared to cognitive-behavioral therapy, schema therapy treatment based on psycho-social issues can play an effective role in reducing the early maladaptive schemas and anxiety of these patients.

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Introduction

Obsessive-compulsive disorder is a debilitating anxiety disorder whose main feature is the occurrence of obsessions and compulsions (American Psychiatric Association, 2013). Obsessions include unwanted, annoying and persistent thoughts, mental images, and impulses, and compulsions are physical or mental actions that lead to the reduction of anxiety caused by obsessive thoughts. A patient with obsessive-compulsive disorder may have mental obsession, practical obsession, or both of them together. The lifetime prevalence of obsessive-compulsive disorder in the general population is about two to three percent. Among adults, the probability of having this disorder is the same for men and women. The onset age of this disorder is about twenty years old, and of course it is a little earlier in men (about nineteen years old) and later in women (about twenty-two years old) (Blach et al., 2015). One of the main characteristics of obsessive-compulsive disorder is damage to the functions and interpersonal relationships of the person suffering from the disorder (American Psychiatric Association, 2013). As far as it has been seen, these people either do not establish intimate and close relationships or are not able to maintain their relationships. What has a direct impact on people's interpretation of interpersonal relationships is the individual's mental schemas. A schema is a template that is formed over reality or experience to help people explain their experiences. Schemas are considered to be a factor in the organization of the whole body and are essential to understanding life experiences. Schemas influence the processing of subsequent experiences (Young et al., 2006).

As expected, schemas are the foundation of each person's cognitive style, beliefs and thoughts (Beck, 2005). Early maladaptive schemas represent core beliefs about self and others and bias the processing of external information into dysfunctional paths. Therefore, they affect interpersonal relationships and self-perception. Early maladaptive schemas are more unconditioned and spontaneous and are capable of generating high levels of negative affect (Harris & Curtin, 2002). Research results show that early maladaptive schemas are related to psychological symptoms and negative life experiences and events, and these schemas directly and indirectly lead to the creation and chronicity of various forms of mental disturbances, including obsessive-compulsive disorder. (Gudarzi et al., 2016). In various researches, anxiety and depression are considered the most important causes of obsessional disease, that excessive anxiety causes obsessive thinking and action, and the root of both types of obsessions is thought and action, in such a way that the patient is anxious for any reason. Anxiety is a vague and unpleasant feeling, the source of which is often unknown to people (Springer et al., 2004). Anxiety is defined as worrying about future dangers or misfortunes, which is accompanied by feelings of lack of pleasure or signs of physical tension. In this definition, the source of anticipated danger can be internal or external (Kaplan & Sadok, 2007). People with obsessive-compulsive disorder are helpless due to chronic and intense feelings of anxiety. These feelings are so strong that people with this disorder are unable to perform their daily activities. Anxiety makes these people uncomfortable and makes them unable to enjoy normal situations, in addition, these people try to avoid situations that make them feel anxious (Halgin, 2004).

Various models and theories have been presented to explain and treat obsessive-compulsive disorder, which range from psychoanalysis to new postmodern models. each of which emphasizes a specific factor. Among the models and treatment patterns proposed in the treatment of obsessive-compulsive disorder are: Behavioral theories of O'Conner et al.'s conceptualization model (2005), Salkoskis' cognitive model (1989), Rockman's cognitive-behavioral therapy model (Rachman, 1998) and Wells' metacognition model (Wells & Mathews, 1996). Researches by Alavi Padayar et al. (2017), Hassanzadeh and Sarabandi (2015) and Coles et al. (2014) show that cognitive behavioral therapy reduces rumination in patients with obsessive-compulsive disorder. Also, Storch et al. (2007) showed that cognitive behavioral therapy is more effective when combined with other treatments. According to the studies, although cognitive-behavioral therapy interventions have good empirical support, meta-analytical results showed that only 50% of patients achieved significant improvement in follow-up studies (Fisher &

Wells, 2008). In the cognitive behavioral therapy approach, too much importance is given to intrapsychic phenomena, and interpersonal processes are not considered as much as they should be (Bourkok et al., 2003). Also, in these treatments, mood is not taken into account, while many theorists in the field of pathology believe that mood plays an undeniable role in the formation and continuation of psychological problems and psychological issues (Lechnal-Chowalt et al., 2006). Overall, the research results indicate that factors such as insecure attachment style, interpersonal problems, inconsistent temperament, interpersonal schemas, and cognitive behavioral problems reduce cognitive behavioral effects (Fisher & Wells, 2008). On the other hand, research results have indicated the effectiveness of schema therapy in improving anxiety disorders and depression (Renner et al., 2012). Also, research results show that schema therapy training increases people's mental health (Zarepoosh et al., 2012). Schema therapy emphasizes the developmental origins of psychological problems in childhood and adolescence, the use of motivational techniques, and the concept of maladaptive coping styles (Pinto-Govia et al., 2006). This method of therapy combines the principles and foundations of cognitive-behavioral, attachment, gestalt, object relations, constructivism, and psychoanalysis schools in the form of a therapeutic model and a valuable concept (Esteki azad et al, 2022; Sohrabi, 2015). Schema therapy theorists believe that they have designed and developed a suitable solution for the treatment of cognitive behavioral disorder. Sukman and Sticetti (2007) believes that the presence and activation of vulnerable schemas is one of the characteristics of people who are afraid to accept the perceived risk of exposure and response prevention. Young et al. (2003) hypothesized that certain schemas, particularly those formed during early life as a result of adverse childhood experiences, may form the core of personality disorders, milder trait problems, and many chronic axis one disorders.
Researches show that schemas play an important role in the formation process of obsessive-compulsive disorder. In cognitive theories, schemas are considered the deepest psychological level, which lead to the expansion of obsessive beliefs, ineffective attitudes and negative thoughts (inefficient cognition) at different levels. That is, the schema causes people to make mistakes when drawing conclusions from their experiences, make arbitrary and immediate conclusions, give leaves to issues and find obsessive beliefs (Sangnani & Dasht Bozorgi, 2018). In a research conducted by Sanganani and Dasht Bozorgi (2018), the results showed that schema therapy is useful for rumination. Despite these issues and the review of etiological research and treatment regarding obsessive-compulsive disorder, it shows that each of these conceptualizations play a role in justifying a part of the formation and continuation of obsessive symptoms. Trying to distinguish different schools and techniques effective in the treatment of various psychological disorders seems necessary. Considering the limitation of financial resources and the importance of time in today's life, choosing the most efficient and least expensive treatment is considered a very important action for clients of psychological services and researchers in the field of treatment. Based on the presented materials, schema therapy based on psycho-social issues has not been done. Not even much attention has been paid to examining the psycho-social issues of obsessive-compulsive patients, such as interpersonal relationships, interpersonal schemas, secretarial problems, and recognition of anxiety, depression, fear, stress, etc. Therefore, what is considered in this research is to compare the effectiveness of the schema therapy package based on psycho-social issues of patients with obsessive-compulsive disorder with cognitive behavioral therapy on early maladaptive schemas and anxiety in people with obsessive-compulsive disorder.

Method

The current research is a semi-experimental method of pre-test, post-test and follow-up with the control group. The statistical population of this study included all people suffering from obsessive-compulsive disorder in the age range of 15-25 years who referred to specialized psychotherapy centers in the field of obsessive-compulsive disorder located in Isfahan city in the spring and summer of 2019. According to previous studies, a sample size of 15 people was selected for each experimental group. In total, 45 sample people were selected as available and randomly replaced in two experimental groups (schema therapy based on psychosocial issues and cognitive-behavioral therapy) and the

control group. The criteria for inclusion in the study were obsessive-compulsive disorder, age 15 to 25 years, literacy level at least up to elementary school level, receiving medical interventions, not receiving simultaneous therapeutic interventions. The exclusion criteria for this study included having at least 2 absentee sessions in the intervention process, suffering from addiction, suffering from other psychiatric disorders as diagnosed by a psychiatrist.

Materials

1. Young's schema questionnaire (Short form). This scale was developed by Young (1997) and is a self-report measurement tool to measure schemas. This questionnaire has 90 items and specifies 18 schemas in 5 areas. The short form is used more in research because it takes less time to complete. Questionnaire items are grouped by schemas. In front of each group of items, there is a two-letter code that indicates which schema was measured. Then, in the treatment session, the therapist together with the patient identify the items that have been given a high score (usually 5 or 6) and the therapist asks the patient questions about those items to determine exactly the schemas. The reliability and validity of this tool has been proven in several studies (Shahamat, Thabiti and Rezvani, 2009). The results of the research of Lakhnal-Cholet, et al. (2006) showed that Cronbach's alpha of this questionnaire is 0.64 to 0.87.

2. Beck Anxiety Inventory (BAI). This 21-question questionnaire was developed in 1988 by Beck et al. in 1989 to measure the overall intensity of anxiety. The participant rates the severity of each symptom using a four-point scale ranging from (not at all) to (extremely I can't stand it). Grading is done by summing the scores of 21 questions. In total, the score of the participants varies between 0 and 63. A score less than 9 indicates no anxiety, a score between 10 and 20 indicates mild anxiety, a score between 21 and 30 indicates moderate anxiety, and 31 and above indicates severe anxiety. The alpha coefficient of 0.92 was also obtained for the questionnaire on 160 outpatients.

3. Schema therapy sessions based on psycho-social issues. Schema therapy based on psycho-social issues based on Young et al.'s package therapy (2003) was implemented during ten 60-minute sessions weekly for two and a half months.

Table 1. Description of schema therapy sessions based on psychosocial issues

Session	Content
1	Recognizing obsessive-compulsive disorder and introducing programs for therapy sessions listing problems, identifying compulsions, avoidances and fundamental beliefs and distorted thoughts and cognitive beliefs and expressing active schemas in obsessive-compulsive disorder based on the psychosocial model and active schemas in this field. including (cut and rejection schema, emotional deprivation schema, stubborn standards schema, mistrust schema, defect schema, punishment schema, ear-to-ear schema
2	Getting to know the pattern of schema therapy based on psychosocial issues and conceptualizing the patient's problem in the form of active schemas in the cognitive domain (the schemas of the first domain of rejection and cutting and the fifth domain of ringing bells); Modifying the schema (stubborn criteria, rejection, separation, and defects), using cognitive techniques based on activating the schema and accepting the individual's self-worth.
3	Continuing to modify the schema (stubborn criteria, rejection and separation and defects), using cognitive techniques based on activation of the schema and acceptance of the individual's self-worth.
4	Continuing to modify the schema (stubborn criteria, rejection and separation and defects), using cognitive techniques based on activation of the schema and acceptance of the individual's self-worth.
5	Continuing to modify the schema (stubborn criteria, rejection and separation and defects), using cognitive techniques based on activation of the schema and acceptance of the individual's self-worth.
6	Getting to know the schema therapy model based on psychosocial issues and conceptualizing the patient's problem in the form of active schemas in the emotional domain (the schemas of the first domain of rejection and cutting and the schema of the fifth domain of ringing bells); Schema modification (ringing ears, mistrust, emotional deprivation), using emotional techniques and emotional schema therapy to eliminate dysfunctional active schemas.
7	Continuing schema modification (ringing ears, mistrust, emotional deprivation), using emotional techniques and emotional schema therapy to eliminate dysfunctional active schemas.

8	Continuing schema modification (ringing ears, mistrust, emotional deprivation), using emotional techniques and emotional schema therapy to eliminate dysfunctional active schemas.
9	Getting to know the pattern of schema therapy based on psychosocial issues and conceptualizing the patient's problem in the form of active schemas in the behavioral domain (the schemas of the first domain of rejection and cutting and the fifth domain of ringing bells); Modifying the schema (punishment, stubborn criteria) using behavioral techniques and teaching interpersonal communication skills, decision-making and empathy
10	Continuing to modify the schema (punishment, stubborn criteria) using behavioral techniques and training interpersonal communication skills, decision-making and empathy, identifying and introducing damage to the relationship with parents, teaching coping skills and damage to the relationship with parents; Using family therapy techniques based on schema therapy to persuade and encourage clients to let go of maladaptive coping styles; Have the client prepare a list of skills learned and treatment. Helping the patient to generalize the gains of the treatment to the real life environment

4. Cognitive-behavioral therapy sessions. Cognitive-behavioral therapy based on Strouch et al.'s (2007) package therapy was implemented during ten 60-minute sessions weekly for two and a half months.

Table 2. Description of cognitive-behavioral therapy sessions

Session	Content
1	General familiarity with the symptoms of obsessive-compulsive disorder. Giving a list of images of disturbing thoughts of ordinary people, practicing relaxation
2	Drawing a cognitive model of obsession, normalizing obsessive thoughts and drawing a cognitive triangle, giving a list of all types of cognitive errors, filling in a thought registration form and conducting behavioral tests.
3	Using cognitive techniques, Socratic questioning and reviewing the 5-column sheet of thoughts, filling in the 7-column sheet of thoughts, writing a list of benefits and accompanying disturbing thoughts, conducting a behavioral experiment for the importance of thoughts.
4	Examining the form of recording daily thoughts, behavioral testing for the act of neutralizing thoughts, using probability calculation techniques and Socratic questioning for belief, overestimating risk, behavioral experimental design for belief seeking reassurance
5	Socratic questioning and implementation of pie chart technique and pie chart standard technique and double standard technique for extreme responsibility belief
6-9	Teaching and implementing the technique of confronting and preventing the response and practicing it in the presence of the therapist, designing behavioral experiments for the importance of thoughts.
10	Reviewing and summarizing cognitive and behavioral techniques for explaining self-symptoms and teaching problem-solving steps

Implementation

The first group of the experiment received the therapy package compiled based on psychosocial issues for patients with obsessive-compulsive disorder for 10 sessions of 2 hours. The techniques and exercises of that session were used in each session. Assignments were given at the end of each session. In the last session, the post-test was conducted. The second group of the experiment received cognitive-behavioral therapy derived from Wilhem and Stecti's behavioral therapy sessions for 10 2-hour sessions. In each session, the techniques and exercises of that session were used. Assignments were given at the end of each session. In the last session, the post-test was conducted. Tables 1 and 2 provide a summary of the sessions in the experimental groups. Also, there was no intervention during this period on the control group. All three groups responded to the respective questionnaires before and after the treatment sessions, as well as after 45 days in the follow-up phase. Also, in addition to obtaining written consent, the ethical principles of confidentiality,

using data only in line with the research objectives, freedom and full authority of the participants to withdraw and detailed information if the participants request the results, were among the ethical principles used in this study.

Results

The results of demographic analysis on 45 participating patients showed that these people had an average age of 19.95 (standard deviation = 3.05), 23 were women and 22 were men. Most people were single (64%), and the rest were married. On average, the duration of the disease history of the subjects was reported to be 5.15 months (standard deviation = 1.63). In total, 14 of the patients were students, and the rest had jobs such as students (10 people), housekeepers (8 people), and self-employed (18 people). Descriptive findings of early maladaptive schemas by intervention and control groups are presented in Figure 3. As can be seen in Table 3, the average scores of initial maladaptive schemas in the intervention groups (schema therapy based on psycho-social issues and cognitive-behavioral therapy) have a greater decrease in the post-test and follow-up phases than in the pre-test compared to the control group.

Table 3. Descriptive indices of scores of primary maladaptive schemas by three groups

Variable	Group	Pre-test		Post-test		Follow-up	
		Mean	SD	Mean	SD	Mean	SD
Early Maladaptive Schemas	Schema	4/52	0/67	1/81	2/79	2/53	2/51
	CBT	4/38	0/61	3/18	8/49	13/27	7/32
	Control	4/3	0/68	4/42	10/24	15/13	9/71
Anxiety	Schema	48/93	12/93	6/47	2/79	2/53	2/51
	CBT	47/13	14/15	28	8/49	13/27	7/32
	Control	41/86	13/88	38/47	10/24	15/13	9/71

Before performing comparative analyzes between the two treatments, statistical assumptions were first examined. The results of the implementation of the assumption of normality of the distribution of grades using the Kolmogorov-Smirnov test showed that the null hypothesis of the normality of the distribution of grades in the initial inconsistent schemas variable was confirmed in all three groups in all three stages of the research ($p < 0.05$). The results of Levene's test to check the assumption of equality of variances have shown that Levin's assumption of equality of variances in groups in the initial inconsistent schemas variable has been confirmed in the pre-test and follow-up phases ($p < 0.05$). The results of the Mauchly's test to check the assumption of uniformity of covariances or the equality of covariances with covariance showed that the assumption of uniformity of covariances has been rejected using the Mauchly test ($p < 0.5$). The results of the comparison between the subjects, i.e., the comparison in the rumination variable, are presented in Table 4.

Table 4. The results of the analysis of between-subject effects in the early maladaptive schema variable and anxiety

Variable	Source	SS	Df	MS	F	Sig	Eta^2
Early Maladaptive Schemas	Group	72/655	2	36/327	33/06	0/001	0/612
	Error	46/152	42	1/099			
Anxiety	Group	9845/528	2	4922/763	11/264	0/001	0/349
	Error	18354/667	42	437/016			

Based on the findings in Table 4, the average scores of early maladaptive schema and anxiety in two experimental groups (schema therapy based on psycho-social issues and cognitive-behavioral therapy) show a significant difference ($p<0.001$). The results have shown that 61.2% of the individual differences are related to the differences between the three groups. Considering the significance of the interaction of time and group membership, the results of parameter estimation to compare groups in the research stages are presented in Table 5.

Table 5. The results of parameter estimation by separation of dependent variables or mean scores of early maladaptive schemas in study phases					
Phase	Groups	B	SE	t	Sig
Pre-test	Schema and Control	0/219	0/239	0/916	0/365
	CBT and Control	0/079	0/239	0/329	0/744
	Schema and CBT	0-/14	0/239	0-/916	0/365
Post-test	Schema and Control	2-/61	0/224	11-/67	0/001
	CBT and Control	1-/24	0/224	5-/54	0/001
	Schema and CBT	1/37	0/224	6/12	0/001
Follow-up	Schema and Control	2-/99	0/246	12-/16	0/001
	CBT and Control	1-/68	0/246	6-/83	0/001
	Schema and CBT	3/31	0/246	5/34	0/001

The results in Table 5 show that there is no significant difference between the average scores of the initial maladaptive schemas of all three groups in the pre-test stage. However, the results have shown that there is a significant difference in the mentioned variable in both the post-test and follow-up stages between the control group and the schema therapy group focused on psycho-social issues ($p<0.001$), and cognitive-behavioral therapy ($p<0.001$). has it. Therefore, the results show that the effectiveness of schema therapy and cognitive-behavioral therapy in the post-test phase is equal to 76.4 and 42.3 percent, respectively, and the effectiveness of these treatments in the follow-up phase is equal to 77.9 and 52.6 percent, respectively. Is. In both the post-test and follow-up stages, the difference between schema therapy and cognitive-behavioral therapy groups is significant ($p<0.001$).

Table 6. The results of parameter estimation according to dependent variables or mean anxiety scores in study phases						
Phase	Groups	B	SE	t	Sig	Effect size
Pre-test	Schema and Control	7/07	4/99	1/416	0/164	0/046
	CBT and Control	5/27	4/99	1/055	0/297	0/026
	Schema and CBT	1-/8	4/99	0-/361	0/72	0/003
Post-test	Schema and Control	32-	4/74	6-/75	0/001	0/521
	CBT and Control	10-/47	4/74	2-/21	0/033	0/104
	Schema and CBT	21/53	4/73	4/544	0/001	0/33
Follow-up	Schema and Control	36-/33	4/77	7-/62	0/001	0/58
	CBT and Control	13-/67	4/77	2-/86	0/006	0/163
	Schema and CBT	22/66	4/77	4/75	0/001	0/58

The results in Table 6 show that there is no significant difference in the average anxiety scores of all three groups in the pre-test stage. However, the results have shown that there is a significant difference between the control group and the schema therapy group based on psycho-social issues ($p<0.001$), and cognitive-behavioral therapy ($p<0.001$) in both post-test and follow-up stages. has it. Therefore, the results show that the effectiveness of schema therapy and cognitive-behavioral therapy in the post-test phase is equal to 52.1 and 10.4 percent, respectively, and the effectiveness of these treatments in the follow-up phase is equal to 58 and 16.3 percent, respectively. In both the post-test and follow-up stages, the difference between schema therapy and cognitive-behavioral therapy groups is significant ($p<0.001$).

Conclusion

The findings of the research are in line with the findings of Vital, Torderson and McLean (2005), Deshiri (2012) that cognitive-behavioral therapy is effective in reducing anxiety in patients with obsessive-compulsive disorder. Also, the findings of the research are in line with the findings of Maleki et al. (2015),

Capron et al. (2013), Storch et al. (2007) and Vital et al. (2005) that schema therapy is effective in reducing anxiety.

In explaining this finding, anxious people overestimate the amount of risk and probability of being hurt in a specific situation and underestimate their ability to cope with perceived threats due to unrealistic thoughts and false beliefs. According to Ellis, emotions are influenced by opinions, evaluations and interpretations. Humans like to shape their desires and preferences as they should. These small needs create disturbing feelings and behaviors. Perhaps it can be said that the reason for the success of schema therapy based on psychosocial issues is the use of certain techniques, including the experimental technique, which uses the experimental technique of working on physical, emotional feelings, memories, and mental images. Clients fought with maladaptive schemas with the help of experimental techniques on an emotional level and expressed their anger and discomfort towards childhood incidents using mental imagery. Once these techniques are learned, they are used throughout life and when a person sees the result, he gives himself positive feedback. Ultimately, this reduces anxiety and since this package therapy is focused on early maladaptive schemas that are formed due to psychological and avoidance issues in the individual. Therefore, maladaptive schemas are identified and the person fights against them, and by using existing techniques and frequent use, it leads to the change of the schema and the ultimate reduction of anxiety behavior. Cognitive therapy is not able to change schemas. Therefore, schema therapy based on psychosocial issues pays attention to past bitter experiences that play a significant role in the formation of deep beliefs and ineffective schemas. By using experimental techniques, by reconstructing these memories and cognitions and helping to express and discharge negative and suppressed emotions and emotions, this treatment improves the condition and reduces anxiety. On the other hand, the main goal of schema therapy and this package therapy is that patients change significantly, and such an attitude has a significant effect on the freedom of the patient and the therapist regarding the order of treatment sessions, the type of interventions and how to use techniques. On the other hand, schema therapy attaches great importance to basic needs and transformational processes. It is true that cognitive therapy also considers emotional needs and childhood experiences to be effective in the formation of personality. However, it has not specified what emotional needs exist and how childhood experiences are formed in the formation of schemas and mentalities. In other words, in cognitive therapy, issues are not paid attention to, and this can be an advantage of schema therapy in improving the problems of patients suffering from obsessive-compulsive disorder, including anxiety. Also, since the compiled treatment package fundamentally and fundamentally examines the psychological and social issues of the patients and identifies the schemas involved in this field and tries to change them. Schema therapy based on psychosocial issues, with the conducted investigations, has investigated the amount of treatment sessions allocated to cognitive, emotional and behavioral areas and has been able to help patients with obsessive-compulsive disorder in reducing symptoms by allocating the necessary number of sessions in each area. (Storch et al., 2007). It is suggested that in order to reduce early maladaptive schemas and anxiety, the schema therapy method based on psycho-social issues of patients with obsessive-compulsive disorder should be used in counseling and psychotherapy centers (clinical environments) and educational meetings and workshops for counselors and therapists should be organized with this approach. It is also suggested that these approaches be tested on other groups to estimate its validity with higher confidence. On the other hand, every research has special limitations and the interpretation of the results should be considered in the light of these limitations. Among the limitations of this research, due to the fact that the population of this research was OCD sufferers, caution should be taken in generalizing these results to other groups.

Conflict of Interest

According to the authors, this article has no financial sponsor or conflict of interest.

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