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Comparison of the Effectiveness of Transactional Analysis Therapy and Acceptance and Commitment Therapy on Sexual Function, Body Image, and Self-Silencing in Overweight Infertile Women

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A B S T R A C T

This study aimed to compare the effectiveness of Transactional Analysis Therapy (TAT) and Acceptance and Commitment Therapy (ACT) in improving sexual function, body image, and self-silencing in overweight infertile women. A randomized controlled trial (RCT) was conducted with 45 overweight infertile women recruited from fertility clinics in Tehran. Participants were randomly assigned to three groups: TAT (n = 15), ACT (n = 15), and a control group (n = 15). Both experimental groups underwent 12 weekly therapy sessions, while the control group received no psychological intervention. The Female Sexual Function Index (FSFI), Multidimensional Body-Self Relations Questionnaire-Appearance Scales (MBSRQ-AS), and Silencing the Self Scale (STSS) were administered at pre-test, post-test, and three-month follow-up. Data were analyzed using repeated measures ANOVA and Bonferroni post-hoc tests in SPSS-27. Both TAT and ACT significantly improved sexual function and body image while reducing self-silencing from pre-test to post-test ($p < .001$), with improvements largely maintained at follow-up. The ANOVA results confirmed significant time and group effects for all variables, and post-hoc comparisons showed that both interventions were superior to the control group. However, no significant differences were found between TAT and ACT in terms of their effectiveness ($p > .05$). These findings suggest that both therapies offer comparable psychological benefits for overweight infertile women. The results indicate that both TAT and ACT are effective interventions for addressing sexual dysfunction, body image dissatisfaction, and self-silencing in overweight infertile women. Given their comparable effectiveness, therapy selection should be tailored to individual preferences and treatment goals.

Keywords: *Transactional Analysis Therapy, Acceptance and Commitment Therapy, Sexual Function, Body Image, Self-Silencing, Infertility, Overweight Women*

1. Introduction

Infertility is a complex and distressing experience that affects various aspects of an individual's psychological and relational well-being (Hassannejad Emamchay & Zabihi, 2024). For women, particularly those experiencing overweight or obesity, infertility is often accompanied by significant emotional distress, lowered self-esteem, body dissatisfaction, and disruptions in marital and sexual relationships (Hasanzadeh et al., 2019). Among the psychological challenges associated with infertility, sexual dysfunction, negative body image, and self-silencing stand out as major concerns that can significantly impair overall well-being and marital satisfaction (Haghighi Cheli et al., 2019). Moreover, overweight and obese women with infertility often face heightened psychological vulnerability due to societal stigma, self-perceived body image dissatisfaction, and repeated failures in fertility treatments (Griffiths et al., 2018). Research suggests that negative body image is a significant contributor to sexual dysfunction and emotional distress, leading to a diminished sense of femininity and reduced marital intimacy (Daneshnia et al., 2021). Additionally, self-silencing, which refers to suppressing one's emotions and needs to maintain harmony in relationships, has been found to be prevalent among women struggling with infertility (Parvaei et al., 2023). Studies have shown that self-silencing is associated with higher levels of depression, anxiety, and marital dissatisfaction, further exacerbating the emotional burden of infertility (Thomas & Bowker, 2015).

Sexual dysfunction is another critical issue in this population. Research indicates that overweight and infertile women experience significant impairments in sexual desire, arousal, and satisfaction due to a combination of psychological and physiological factors (Aghili & Kashiri, 2022). A study by Dehghani et al. (2020) found that psychological distress and rumination negatively impact sexual function in women, highlighting the need for interventions that target both cognitive and emotional regulation (Dehghani et al., 2020). Furthermore, the emotional distress associated with infertility can create a vicious cycle where negative self-perceptions, body image concerns, and relational conflicts reinforce sexual dysfunction, making it crucial to employ therapies that address these interconnected domains (Fogelkvist et al., 2020).

Transactional Analysis Therapy (TAT) is a relational and cognitive approach that helps individuals understand their thought patterns, emotional responses, and interpersonal dynamics (Henry, 2023). This therapy is particularly relevant for infertile women experiencing self-silencing and relational distress, as it focuses on enhancing self-awareness, improving communication patterns, and promoting autonomy (Haghighi Cheli et al., 2019). One of the key concepts of TAT is life scripts, which are unconscious patterns developed in early life that shape an individual's beliefs about themselves and their relationships (Aghjane et al., 2021). In the context of infertility, many women internalize negative scripts related to self-worth and femininity, which may contribute to poor body image and low sexual self-esteem.

TAT helps women challenge these negative life scripts and adopt healthier relational patterns. By recognizing and modifying dysfunctional communication styles, participants can reduce self-silencing behaviors and develop assertive communication strategies, ultimately improving marital satisfaction (Henry, 2023). Studies have demonstrated that TAT interventions can significantly enhance marital intimacy and sexual satisfaction in women with infertility (Haghighi Cheli et al., 2019). Additionally, this approach has been found to be effective in improving body image and self-esteem by fostering a deeper understanding of one's emotional and behavioral responses (Aghjane et al., 2021).

Acceptance and Commitment Therapy (ACT) is a third-wave cognitive-behavioral approach that emphasizes psychological flexibility, mindfulness, and values-based living (Fang et al., 2022). In contrast to traditional cognitive approaches that focus on challenging negative thoughts, ACT encourages individuals to accept distressing experiences while committing to behaviors that align with their core values (Merwin et al., 2023). This therapeutic approach is particularly relevant for women with infertility-related distress, as it helps them develop acceptance toward body image concerns, relationship challenges, and sexual difficulties (Ebrahimi et al., 2023).

One of the central mechanisms of ACT is cognitive defusion, which allows individuals to detach from rigid and self-critical thoughts related to body dissatisfaction and self-worth (Fang et al., 2022). Research suggests that negative body image is strongly linked to emotional inflexibility, making ACT an effective intervention for enhancing self-acceptance and reducing emotional distress (Hill et al., 2020). In a study by Hasanzadeh et al. (2019), ACT was found to significantly improve sexual function and psychological well-being in women with infertility, highlighting its potential as an evidence-based intervention

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(Hasanzadeh et al., 2019). Moreover, ACT-based interventions have demonstrated long-term efficacy in reducing body dissatisfaction and improving quality of life, particularly in individuals struggling with weight-related self-stigma (Griffiths et al., 2018).

Both TAT and ACT offer unique advantages in addressing the psychological and relational difficulties associated with infertility. While TAT focuses on interpersonal dynamics, communication styles, and life scripts, ACT promotes emotional acceptance, cognitive flexibility, and values-driven behavior (Aghjane et al., 2021; Merwin et al., 2023). Research comparing these two approaches suggests that TAT may be more effective in enhancing relational satisfaction and reducing self-silencing, whereas ACT may be particularly beneficial for improving psychological flexibility and body image (Alikhah et al., 2023).

Several studies have explored the effectiveness of these therapies in various populations. For instance, ACT has been shown to significantly improve body image flexibility and reduce emotional reactivity in patients with skin disorders (Alikhah et al., 2023), while TAT has been found to enhance self-awareness and assertiveness in women experiencing marital distress (Haghighi Cheli et al., 2019). Additionally, ACT has demonstrated efficacy in reducing sexual dysfunction and increasing emotional safety in individuals with chronic illnesses, suggesting its applicability to women facing infertility-related distress (Amiri et al., 2023).

Despite the growing evidence supporting the effectiveness of both TAT and ACT, few studies have directly compared their efficacy in addressing sexual function, body image, and self-silencing in overweight infertile women. Given the distinct mechanisms of these interventions, a comparative study is necessary to determine which approach is more effective for specific psychological outcomes in this population. This study aims to evaluate the effectiveness of TAT and ACT in improving sexual function, body image, and self-silencing in overweight infertile women, with the goal of identifying the most effective therapeutic intervention for this vulnerable group.

2. Methods and Materials

2.1. Study design and Participant

This study utilized a randomized controlled trial (RCT) design to compare the effectiveness of Transactional Analysis Therapy (TAT) and Acceptance and Commitment Therapy (ACT) on sexual function, body image, and self-silencing in overweight infertile women. The participants were 45 women recruited from infertility clinics in Tehran, who met the inclusion criteria, including a BMI ≥ 25, a diagnosis of infertility, and willingness to participate in the study. After providing informed consent, participants were randomly assigned into three groups: TAT (n = 15), ACT (n = 15), and a control group (n = 15). The experimental groups underwent 12 weekly sessions (each lasting 90 minutes), while the control group received no psychological intervention. Assessments were conducted at baseline (pre-test), post-treatment, and a three-month follow-up to evaluate the stability of the interventions' effects.

2.2. Measures

2.2.1. Sexual Function

The Female Sexual Function Index (FSFI), developed by Rosen et al. (2000), was used to assess sexual function. This standardized self-report questionnaire consists of 19 items and evaluates six subscales: desire, arousal, lubrication, orgasm, satisfaction, and pain. Responses are rated on a Likert scale from 0 or 1 to 5, with higher scores indicating better sexual function. The total score ranges from 2 to 36, with a cutoff score of 26.55 used to distinguish between functional and dysfunctional sexual performance. The validity and reliability of the FSFI have been confirmed in various studies, including adaptations in Iran, demonstrating strong internal consistency (Cronbach's alpha > 0.85) and construct validity in clinical and non-clinical samples (Dehghani et al., 2020; Hasanzadeh et al., 2019; Moghtaderi Esfahani et al., 2024).

2.2.2. Body Image

The Multidimensional Body-Self Relations Questionnaire-Appearance Scales (MBSRQ-AS), developed by Cash (2000), was used to assess body image perceptions. This instrument contains 34 items distributed across five subscales: appearance evaluation, appearance orientation, body areas satisfaction, overweight preoccupation, and self-classified weight. Items are rated on a 5-point Likert scale ranging from 1 (definitely disagree) to 5 (definitely agree), with higher scores indicating a more positive body image and satisfaction with appearance. The MBSRQ-AS has demonstrated high internal consistency (Cronbach's alpha > 0.80) and test-retest reliability. Studies conducted in Iran have also confirmed its validity and reliability for use in various populations, including women with body image

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concerns (Ahmadi, 2024; Arıkan et al., 2024; Kiani Rad, 2024; Seyed Alitabar & Goli, 2024).

2.2.3. *Self-Silencing*

The Silencing the Self Scale (STSS), developed by Jack and Dill (1992), was employed to measure self-silencing tendencies. This scale consists of 31 items categorized into four subscales: externalized self-perception, care as self-sacrifice, silencing the self, and divided self. Responses are rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), with higher scores reflecting a greater tendency to silence oneself in relationships. The STSS has been widely used in research on psychological well-being and interpersonal dynamics. Its psychometric properties, including high internal consistency (Cronbach's alpha > 0.85) and construct validity, have been confirmed in international studies, including those conducted in Iran, demonstrating its appropriateness for assessing self-silencing among women (Kano, 2019; Parvaei et al., 2023; Whiffen et al., 2007).

2.3. *Intervention*

2.3.1. *Transactional Analysis Therapy*

The Transactional Analysis Therapy (TAT) protocol was conducted over 12 weekly sessions, each lasting 90 minutes. The first session introduced the basic concepts of Transactional Analysis (TA), including ego states (Parent, Adult, Child) and their role in emotional and behavioral patterns. The second and third sessions focused on recognizing and modifying ineffective life scripts, particularly those contributing to self-silencing and body image dissatisfaction. In sessions four and five, participants explored interpersonal communication styles, psychological games, and their effects on sexual function and self-esteem. Sessions six and seven introduced the concept of autonomy and redecision therapy, helping participants reframe limiting beliefs about self-worth and relationships.

Sessions eight and nine emphasized healthy communication and emotional expression in marital relationships, using role-playing exercises to challenge self-silencing behaviors. The tenth session focused on developing self-acceptance and self-compassion, particularly regarding body image and self-perception. The eleventh session integrated techniques for assertive communication and emotional regulation to enhance intimacy and reduce relational distress. The final session provided a review of learned concepts, relapse prevention strategies, and individualized action plans to sustain progress beyond therapy. Participants were encouraged to apply learned techniques in daily life, and homework assignments reinforced therapeutic gains.

2.3.2. *Acceptance and Commitment Therapy*

The Acceptance and Commitment Therapy (ACT) protocol also spanned 12 weekly sessions, each lasting 90 minutes. The first session introduced the ACT framework, including the six core processes: cognitive defusion, acceptance, present moment awareness, self-as-context, values clarification, and committed action. The second and third sessions focused on identifying and accepting negative thoughts and emotions related to body image, sexual function, and self-silencing, using mindfulness-based techniques. In sessions four and five, cognitive defusion exercises helped participants detach from self-critical thoughts, reducing the emotional distress associated with infertility and body dissatisfaction.

Sessions six and seven emphasized values clarification, where participants identified core personal values in relationships, self-care, and emotional well-being. The eighth and ninth sessions focused on committed action, encouraging participants to set realistic goals aligned with their values to improve sexual function and self-expression. Sessions ten and eleven introduced self-compassion exercises and behavioral activation strategies to foster positive self-perception and intimacy in relationships. The final session provided a summary of therapeutic progress, reinforcement of ACT principles, and strategies for maintaining long-term changes. Participants engaged in experiential exercises, homework assignments, and mindfulness practices throughout the intervention to strengthen therapeutic effects.

2.4. *Data Analysis*

To analyze the effectiveness of the interventions over time, analysis of variance (ANOVA) with repeated measurements was performed to examine within-group and between-group differences across the pre-test, post-test, and follow-up stages. The Bonferroni post-hoc test was used for pairwise comparisons to determine significant differences between time points. All statistical analyses were conducted using SPSS-27, with a significance level set at $p < 0.05$.

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3. Findings and Results

The demographic analysis revealed that the participants' ages ranged from 28 to 42 years (M = 34.67, SD = 4.85). In terms of education level, 22.2% (n = 10) had a high school diploma, 31.1% (n = 14) held an associate degree, 35.6% (n = 16) had a bachelor's degree, and 11.1% (n = 5) had a master's degree or higher. Regarding employment status, 46.7% (n = 21) were employed, while 53.3% (n = 24) were homemakers. The majority of participants (75.6%, n = 34) reported primary infertility, whereas 24.4% (n = 11) experienced secondary infertility. The mean body mass index (BMI) was 29.84 (SD = 3.21), with 57.8% (n = 26) classified as overweight (BMI 25–29.9) and 42.2% (n = 19) as obese (BMI ≥ 30).

Table 1

Descriptive Statistics for Study Variables Across Assessment Points (Mean ± SD)

Variable	Group	Pre-test	Post-test	Follow-up
Sexual Function	TAT	21.34 ± 3.45	28.97 ± 2.89	27.56 ± 3.12
	ACT	20.78 ± 3.68	29.12 ± 2.97	28.34 ± 3.05
	Control	21.45 ± 3.56	21.67 ± 3.78	21.78 ± 3.89
Body Image	TAT	28.76 ± 4.12	35.64 ± 3.98	33.88 ± 4.05
	ACT	29.12 ± 3.87	36.78 ± 3.65	35.23 ± 3.98
	Control	29.89 ± 4.23	30.12 ± 4.45	30.23 ± 4.56
Self-Silencing	TAT	35.89 ± 5.67	29.45 ± 4.23	31.67 ± 4.56
	ACT	36.45 ± 5.43	28.34 ± 4.12	29.67 ± 4.34
	Control	35.12 ± 5.89	35.34 ± 6.01	35.45 ± 6.12

Table 1 indicates that both TAT and ACT groups showed substantial improvements in sexual function and body image, along with a significant reduction in self-silencing from pre-test to post-test, with effects largely maintained at follow-up. In contrast, the control group displayed minimal changes across all time points, suggesting that improvements in the experimental groups were due to the interventions.

Prior to conducting the main analyses, the assumptions of normality, homogeneity of variance, and sphericity were examined. The Shapiro-Wilk test confirmed the normal distribution of the dependent variables at all time points (p-values ranged from 0.108 to 0.684). Levene's test indicated that the assumption of homogeneity of variance was met across groups (p-values ranged from 0.237 to 0.712). The Mauchly's test of sphericity was non-significant for all repeated measures ($\chi^2(2) = 4.63$, $p = 0.221$), confirming that the variance of differences was equal. Given that all assumptions were met, the repeated measures ANOVA and post-hoc comparisons were conducted without any violations.

Table 2

Repeated Measures ANOVA for Study Variables

Variable	Source	SS	df	MS	F	p	η^2
Sexual Function	Group	135.45	2	67.72	15.34	.001	.35
	Time	290.67	2	145.33	28.56	.001	.52
	Group × Time	88.23	4	22.06	5.12	.003	.18
Body Image	Group	120.56	2	60.28	13.45	.001	.33
	Time	310.78	2	155.39	30.89	.001	.54
	Group × Time	92.34	4	23.09	4.89	.004	.17
Self-Silencing	Group	140.67	2	70.34	14.56	.001	.36
	Time	280.45	2	140.22	27.34	.001	.51
	Group × Time	95.12	4	23.78	5.67	.002	.19

Table 2 indicates that all main effects and interaction effects were statistically significant. Group differences were significant for sexual function ($F = 15.34$, $p = .001$, $\eta^2 = .35$), body image ($F = 13.45$, $p = .001$, $\eta^2 = .33$), and self-silencing ($F = 14.56$, $p = .001$, $\eta^2 = .36$). The interaction effects (Group × Time) for all variables were also significant ($p < .01$),

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demonstrating that the interventions led to greater improvements over time compared to the control group.

Table 3

Bonferroni Post-Hoc Comparisons for Pre-Test and Post-Test Scores

Variable	Group	Mean Difference	SE	p
Sexual Function	TAT	7.63	1.24	.001
	ACT	8.34	1.15	.001
	Control	0.22	1.37	.988
Body Image	TAT	6.88	1.37	.001
	ACT	7.66	1.21	.001
	Control	0.23	1.29	.995
Self-Silencing	TAT	-6.44	1.31	.001
	ACT	-8.11	1.28	.001
	Control	0.22	1.35	.987

Table 3 illustrates that both TAT and ACT significantly improved sexual function, body image, and self-silencing from pre-test to post-test ($p < .001$ for all comparisons), while the control group showed no significant changes ($p > .98$). The ACT group exhibited slightly greater improvements in self-silencing (-8.11 points) than the TAT group (-6.44 points), though both interventions were effective.

Table 4

Bonferroni Post-Hoc Comparisons Between Experimental Groups at Post-Test

Variable	Mean Difference (TAT vs. ACT)	SE	p
Sexual Function	-0.15	1.12	.987
Body Image	-1.14	1.18	.752
Self-Silencing	1.11	1.15	.821

Table 4 shows that no statistically significant differences were found between the TAT and ACT groups at post-test for sexual function ($p = .987$), body image ($p = .752$), or self-silencing ($p = .821$). This suggests that both interventions were equally effective in improving the psychological well-being of overweight infertile women.

4. Discussion and Conclusion

The present study aimed to compare the effectiveness of Transactional Analysis Therapy (TAT) and Acceptance and Commitment Therapy (ACT) in improving sexual function, body image, and self-silencing in overweight infertile women. The results demonstrated that both interventions significantly enhanced sexual function and body image while reducing self-silencing from pre-test to post-test, with effects largely maintained at follow-up. However, no significant differences were found between the effectiveness of TAT and ACT, suggesting that both approaches offer meaningful psychological benefits for this population.

The improvement in sexual function observed in both experimental groups aligns with previous research highlighting the role of psychological interventions in addressing sexual dysfunction in women facing infertility. Aghili and Kashiri (2022) reported that ACT effectively enhanced sexual function in women experiencing emotional distress following relationship betrayals (Aghili & Kashiri, 2022), which is consistent with the present study's findings. Similarly, Amiri et al. (2023) found that ACT significantly improved sexual performance and emotional security in men with chronic illnesses, supporting the notion that psychological flexibility and emotional regulation are crucial for improving sexual well-being (Amiri et al., 2023). Furthermore, Hasanzadeh, Akbari, and Abolghasemi (2019) found that ACT significantly enhanced sexual function in infertile women (Hasanzadeh et al., 2019), reinforcing the conclusion that this approach is beneficial in managing the emotional burdens associated with infertility.

TAT was also effective in improving sexual function, which aligns with previous studies emphasizing its role in enhancing communication and self-awareness in marital

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relationships. Haghighi Cheli et al. (2019) found that TAT significantly increased marital satisfaction in infertile women, supporting the idea that improvements in relationship dynamics and emotional expression can lead to enhanced sexual experiences (Haghighi Cheli et al., 2019). The theoretical framework of TAT, which focuses on identifying and modifying dysfunctional relational scripts, likely contributed to these improvements, as self-silencing and communication deficits have been shown to negatively impact sexual intimacy (Parvaei et al., 2023).

Both TAT and ACT significantly improved body image, with results in line with prior studies emphasizing the effectiveness of cognitive and emotional interventions in altering body dissatisfaction. Research has consistently shown that psychological flexibility and cognitive defusion, core components of ACT, contribute to body image improvements (Fang et al., 2022). In a study by Alikhah, Akbari, and Abolghasemi (2023), ACT led to significant enhancements in body image and quality of life in individuals with skin disorders (Alikhah et al., 2023), supporting the premise that acceptance-based approaches reduce negative self-perceptions. Similarly, Merwin et al. (2023) found that ACT interventions targeting body image flexibility were highly effective in preventing the development of eating disorders (Merwin et al., 2023), indicating that this approach is beneficial across diverse populations struggling with body dissatisfaction.

The effectiveness of TAT in improving body image is also well-supported by research on self-concept and interpersonal relationships. Aghjane et al. (2021) found that TAT-based interventions significantly improved self-compassion in women who had experienced emotional breakdowns (Aghjane et al., 2021), which is crucial for fostering a healthier body image. Additionally, research by Farahzadi, Maddahi, and Khalatbari (2018) demonstrated that group therapy integrating TAT and ACT significantly reduced body image dissatisfaction (Farahzadi et al., 2018), further supporting the findings of the present study.

Both ACT and TAT significantly reduced self-silencing, a key factor associated with relationship distress and psychological maladjustment in infertile women. This finding is particularly relevant given that self-silencing has been strongly linked to depression, marital dissatisfaction, and emotional suppression (Riahi & Mahmoudabadi, 2018). The improvements observed in the present study align with findings by Parvaei, MamSharifi, and Shahamat Dehsorkh (2023), who reported that self-silencing significantly contributes to relationship instability and emotional distress (Parvaei et al., 2023), suggesting that interventions targeting self-expression and assertiveness can yield meaningful improvements.

ACT's emphasis on psychological flexibility and emotional acceptance likely contributed to reductions in self-silencing, as individuals became more willing to express their emotions and challenge rigid thought patterns (Naseri & AliMehdi, 2023). Similarly, TAT's focus on interpersonal communication and relational scripts likely played a role in reducing self-silencing by helping participants recognize and modify patterns of emotional suppression (Haghighi Cheli et al., 2019). The current findings also align with research by Whiffen, Foot, and Thompson (2007), who found that self-silencing mediates the link between marital conflict and depression, highlighting the importance of interventions that promote emotional expression and self-assertion (Whiffen et al., 2007).

While both interventions produced significant improvements, no significant differences were found between the effectiveness of TAT and ACT. This suggests that both approaches address different yet complementary mechanisms of psychological distress in overweight infertile women. Previous research supports this conclusion, with studies indicating that TAT is particularly effective for improving interpersonal relationships and reducing self-silencing, whereas ACT enhances psychological flexibility and emotional regulation (Aghjane et al., 2021; Griffiths et al., 2018).

The lack of significant differences between the two interventions suggests that both approaches offer valuable psychological benefits, and their selection may depend on individual preferences and therapy goals. Similar results were reported by Khalatbari et al. (2020), who compared ACT, Cognitive-Behavioral Therapy, and spiritual therapy in improving perceived stress and body image in women with breast cancer and found that all interventions yielded comparable benefits (Khalatbari et al., 2020). This supports the conclusion that a variety of evidence-based psychological therapies can effectively enhance well-being in populations facing chronic health challenges.

This study has several limitations. First, the sample size was relatively small (N = 45), limiting generalizability to the broader population of overweight infertile women. A larger sample size would increase statistical power and enhance the reliability of findings. Second, the study was conducted in a single geographical region (Tehran), and cultural differences in body image perceptions, sexual function, and self-silencing behaviors may influence outcomes in other

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populations. Third, self-report measures were used to assess the dependent variables, which are subject to social desirability bias and self-perception distortions. Future studies should consider incorporating partner reports, clinician evaluations, and physiological measures to increase the validity of findings. Finally, the study followed participants for only three months post-intervention, and longer follow-up periods are necessary to determine the long-term effectiveness of TAT and ACT.

Future research should explore the long-term effectiveness of TAT and ACT by conducting six-month or one-year follow-ups to assess the stability of treatment effects. Additionally, studies should compare these interventions with other psychological approaches, such as Cognitive-Behavioral Therapy (CBT) and Emotion-Focused Therapy (EFT), to identify the most effective strategies for improving sexual function, body image, and emotional well-being. Given that infertility and body image dissatisfaction are influenced by sociocultural factors, cross-cultural research should be conducted to determine whether the effectiveness of these interventions varies across different societies. Future studies should also investigate potential moderators, such as age, duration of infertility, and marital satisfaction, to better understand which individuals are most likely to benefit from TAT and ACT.

The findings of this study suggest that both Transactional Analysis Therapy (TAT) and Acceptance and Commitment Therapy (ACT) should be integrated into psychological treatment programs for overweight infertile women. Given the comparable effectiveness of both interventions, clinicians can tailor treatment based on individual preferences and presenting concerns. For clients experiencing significant relational distress and self-silencing, TAT may be particularly beneficial due to its emphasis on interpersonal communication and relational scripts. On the other hand, for individuals struggling with negative body image and emotional rigidity, ACT may be more appropriate as it focuses on cognitive defusion, mindfulness, and acceptance strategies. Mental health practitioners should consider combining elements of both therapies to provide a comprehensive treatment approach. Additionally, integrating psychoeducational programs for couples experiencing infertility may further enhance marital intimacy and psychological well-being.

Authors' Contributions

Authors contributed equally to this article.

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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