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Comparison of Cognitive Behavioral Therapy and Dialectical Behavior Therapy on Anxiety and Obsessive Beliefs in Patients with Obsessive-Compulsive Disorder

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A B S T R A C T

The present study aimed to compare the effectiveness of Dialectical Behavior Therapy (DBT) and Cognitive Behavioral Therapy (CBT) on anxiety and obsessive beliefs in individuals with OCD. This was a quasi-experimental study using a pretest-posttest control group design. The statistical population consisted of male students with OCD in lower and upper secondary schools in District 14 of Tehran in 2025. From this population, 45 individuals were selected through convenient and purposive sampling, screened, and randomly assigned to experimental and control groups. Data collection instruments included the Maudsley Obsessive-Compulsive Inventory (MOCI; 1977), the Obsessive Beliefs Questionnaire (OBQ-44), and the Beck Anxiety Inventory (BAI; 1988). In the experimental groups, CBT and DBT intervention packages were respectively administered. Data were analyzed using SPSS version 27 and mixed multivariate analysis of variance (MANOVA). The results indicated that both CBT and DBT led to significant reductions in anxiety ($F = 39.23$) and obsessive beliefs ($F = 398.024$) in individuals with OCD compared to the control group (MD = -8.2 and -10.06 for obsessive beliefs, MD = -11.13 and -11.33 for anxiety; $p < .05$). Moreover, DBT was found to be more effective than CBT in reducing obsessive beliefs (MD = 1.86; $p < .05$). Both CBT and DBT interventions were effective in reducing anxiety and obsessive beliefs in individuals with OCD. Given their demonstrated efficacy, these therapeutic approaches can be utilized as effective short- and long-term psychological interventions to reduce anxiety and obsessive beliefs.

Keywords: *Obsessive-Compulsive Disorder, Obsessive Beliefs, Anxiety, Cognitive Behavioral Therapy, Dialectical Behavior Therapy.*

1. Introduction

Obsessive-Compulsive Disorder (OCD) is a highly prevalent and chronic condition associated with significant global disability. OCD is the prototypical example of "Obsessive-Compulsive and Related Disorders," a group of conditions now classified together in both the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) and the *International Classification of Diseases, Eleventh Revision* (ICD-11). These disorders are often underdiagnosed and undertreated. Moreover, OCD serves as a major example of a neuropsychiatric disorder where rigorous investigations into phenomenology, neurobiology, pharmacotherapy, and psychotherapy have contributed to better diagnosis, assessment, and treatment outcomes (Beckner, 2013; Sadeghzadeh, 2024).

OCD is characterized by compulsions and obsessive beliefs, which are intrusive, unwanted thoughts, images, or impulses that cause significant anxiety or distress. Common obsessions include fear of contamination, aggressive impulses, and blasphemous or sexual thoughts (Ramasamy, 2012; Selwood, 2014). OCD is a chronic and debilitating psychiatric disorder marked by intrusive thoughts (obsessions) and repetitive behaviors (compulsions) aimed at reducing the anxiety caused by these obsessions. It is one of the most disabling psychiatric conditions, significantly impacting the quality of life and functioning of affected individuals. OCD has a lifetime prevalence of approximately 2.5% and is ranked by the World Health Organization among the top ten disabling disorders in terms of lost income and reduced quality of life (Beckner, 2013; Kornreich, 2004).

The disorder is associated with substantial functional impairment, and delays in diagnosis and treatment often result from embarrassment and attempts to conceal symptoms (Beckner, 2013; Selwood, 2014). Diagnosis is primarily clinical and guided by DSM and ICD criteria (Kumar, 2012; Taylor, 2009). The etiology of OCD involves a complex interplay of genetic, biological, and environmental factors. Genetic predisposition and chemical imbalances in the brain, particularly involving the striatum, have been implicated (Kornreich, 2004; Stein, 2019). The complexity of this disorder stems from the interaction of these factors and is often accompanied by significant personal and occupational impairment.

Compulsions are repetitive behaviors or mental acts performed to neutralize the anxiety provoked by obsessions. These may include cleaning, checking, counting, or praying (Corcoran & Wolk, 2023; Ramasamy, 2012). Patients often recognize the irrational nature of their obsessions and compulsions, which can further increase their distress (Corcoran & Wolk, 2023; Taylor, 2009).

OCD is a relatively homogeneous disorder with symptom dimensions that are consistent across global populations. Individual assessment of symptoms, degree of insight, belief systems, and comorbidity levels is essential. Several neurobiological mechanisms underlying OCD have been identified, including specific brain circuits. Laboratory models have illustrated how cellular and molecular dysfunction contributes to stereotypical repetitive behaviors, and the genetic architecture of OCD is increasingly being understood. Effective treatments for OCD include selective serotonin reuptake inhibitors (SSRIs), cognitive-behavioral therapy (CBT), and neurosurgical interventions for treatment-resistant cases. Integration of global mental health strategies and translational neuroscience may further advance knowledge and improve clinical outcomes for OCD (Corcoran & Wolk, 2023; Dell'Osso, 2025).

OCD and anxiety disorders share overlapping features, yet remain distinct in diagnostic criteria and treatment approaches. Both disorders are characterized by excessive worry and fear; however, OCD is defined by persistent obsessions and compulsions, while anxiety disorders encompass a broader range of symptoms, including phobias and generalized anxiety. Despite these distinctions, there is considerable comorbidity between OCD and anxiety disorders, suggesting shared etiological factors and therapeutic strategies. This relationship becomes more complex in the presence of personality disorders and other psychiatric comorbidities, such as anxiety disorders that may influence the onset and severity of symptoms. Both OCD and anxiety disorders are influenced by genetic and environmental factors, although OCD demonstrates a higher heritability (Corcoran & Wolk, 2023).

The symptom overlap and severity in studies suggest that anxiety symptoms in OCD may reach levels observed in generalized anxiety disorder, and both conditions involve shared dimensions such as “anxiety” and “obsession” (Evans, 2024). Rather than distinct diagnostic boundaries, clinical manifestations are often determined by symptom severity, and symptom domains are categorized accordingly (Postorino, 2017). CBT and Dialectical Behavior Therapy (DBT) have both shown efficacy for OCD and anxiety disorders (Corcoran & Wolk, 2023; Dell'Osso, 2025). In youth, early intervention with CBT may prevent the progression of these disorders into adulthood (Corcoran & Wolk, 2023).

Both OCD and anxiety disorders exhibit high rates of comorbid personality disorders, particularly cluster C disorders such as Obsessive-Compulsive Personality Disorder (Karaaziz & İskender, 2023; Vigne, 2019). The presence of personality disorders can complicate the treatment and prognosis of OCD and anxiety disorders (Karaaziz & İskender, 2023). Although OCD and anxiety disorders are clinically distinct, their overlapping symptoms and shared treatment strategies highlight the complexity of these conditions. Comorbid disorders complicate diagnosis and treatment, underscoring the need for nuanced approaches to mental health care. Understanding the interaction between these disorders may lead to more effective and individualized treatment programs.

Effective treatments include CBT and pharmacotherapy, particularly SSRIs (Dell'Osso, 2025). In severe cases, neurosurgical intervention may be considered for individuals with treatment-resistant symptoms (Dell'Osso, 2025; Karaaziz & İskender, 2023). CBT aims to reduce the severity of psychiatric disorders by modifying behaviors and cognitions (Clark & Beck, 2010; Hoffman, 2013). CBT for OCD primarily targets maladaptive thoughts and beliefs using behavioral and cognitive techniques (Wells & Carter, 2014). A systematic review has reported that CBT improves symptoms in patients with OCD (Cuijpers, 2014). However, although CBT is effective in reducing negative thoughts in OCD, it has been found to be less effective for generalized anxiety disorder compared to other anxiety disorders (Hoyer & Gloster, 2009). Additionally, in OCD, worries tend to focus on a wide range of issues, and the core causes of obsessions and anxiety remain unclear. CBT encompasses a range of techniques, and it is still undetermined which specific components most effectively target anxiety (Salters-Pedneault, 2006).

Dialectical Behavior Therapy (DBT) is a newer form of psychotherapy that emphasizes emotion regulation, mindfulness, interpersonal effectiveness, and distress tolerance. It was initially developed for treating borderline personality disorder in patients experiencing suicidal ideation and behaviors (Linehan, 1993). DBT primarily focuses on teaching patients to reduce the intensity of emotional dysregulation (Gross & Thompson, 2006). Although DBT skills and strategies have not yet been extensively applied to improve executive functioning in OCD patients, research suggests that these techniques may be beneficial in disorders characterized by emotion regulation difficulties, particularly in generalized anxiety (Boritz, 2018).

To date, DBT has been used to treat other psychiatric disorders such as substance use disorders (Rezaie, 2021), eating disorders, schizophrenia (Van Dijk, 2013), bipolar disorder, and generalized anxiety disorder (Afshari, 2020). However, the potential of DBT to address executive functioning deficits in OCD has not yet been fully explored. Patients with OCD often exhibit characteristics such as limited awareness of emotional experiences, intense emotional reactivity, and an inability to utilize appropriate coping strategies (Wells, 2004). Numerous studies have demonstrated that DBT can be effective in treating emotional dysregulation and disorders marked by such dysfunction (Eisner, 2017).

According to theoretical explanations and the literature review, the occurrence and escalation of compulsive behaviors are primarily attributed to their role in reducing anxiety or obsessive thoughts and beliefs. Increasing attention is now being directed toward the concurrent consideration of cognitive-behavioral beliefs and anxiety in explaining OCD. Previous studies have not simultaneously examined the effectiveness and comparative impact of CBT and DBT on anxiety and obsessive beliefs in patients with OCD. Therefore, the present study aims to compare the effectiveness of Dialectical Behavior Therapy and Cognitive Behavioral Therapy on obsessive beliefs and anxiety in individuals with OCD.

2. Methods and Materials

2.1. Study Design and Participants

The present study was a quasi-experimental design with a pretest-posttest and control group structure. The study population included male high school students with obsessive-compulsive disorder in the second level of secondary education in District 14 of Tehran during the year 2025. To select the sample, after obtaining the necessary permits from 52 schools under the Tehran District 14 Education Department, three boys' high schools were selected. After coordinating with school administrators, a call for participation was sent to students via a messaging platform to invite them to participate in the study. Participants were then screened using the Maudsley Obsessive-Compulsive Inventory (MOCI).

After data collection, among those who met the inclusion and exclusion criteria—and considering that the minimum sample size in quasi-experimental studies is 15 participants per subgroup—the study sample comprised 45 male students with obsessive-compulsive symptoms. They were selected

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through convenience sampling and randomly assigned to three groups of 15. The inclusion criteria included being male, diagnosed with OCD, enrolled in the second level of secondary education, and approximately 17 years old. Exclusion criteria included receiving psychological treatment in the past month, taking psychiatric medications, missing more than one treatment session, or failing to respond to the questionnaires.

To uphold ethical standards, the study emphasized voluntary participation, informed consent, confidentiality of participant data, and the freedom to withdraw at any time. After sampling, both experimental and control groups completed the Beck Anxiety Inventory (1988) and the Obsessive Beliefs Questionnaire (2005) at the pretest stage. The first experimental group then received the Overholser and James (1999) cognitive-behavioral therapy (CBT) package in five 90-minute sessions, while the second experimental group underwent the Linehan (1993) dialectical behavior therapy (DBT) package in eight 90-minute weekly sessions conducted by a trained clinical psychologist. The control group received no treatment. At the end of the therapy sessions, participants in both experimental and control groups completed the Beck Anxiety Inventory and the Obsessive Beliefs Questionnaire again at the posttest stage and one-month follow-up.

2.2. Measures

2.2.1. Obsessive-Compulsive Disorder

Developed by Hodgson and Rachman (1977), this inventory was designed to investigate the type and extent of obsessive-compulsive problems. It includes 30 items, with half keyed as "true" and half as "false." In its initial validation at the Maudsley Hospital, it successfully differentiated 50 OCD patients from 50 neurotic patients. Content analysis of responses from 100 patients revealed four subcomponents representing major types of OCD problems: checking (9 items), cleaning (11 items), slowness (7 items), and doubting (7 items) (Hodgson & Rachman, 1977). The MOCI has demonstrated strong reliability and validity in various clinical populations internationally. For instance, Sanavio reported a correlation of 0.70 between total MOCI scores and the Padua Inventory. Test-retest reliability was found to be high (r = 0.89) (Hodgson & Rachman, 1977). In a study of 40 patients, Hodgson and Rachman (1997) showed the total score was sensitive to treatment changes. MOCI is considered a reliable tool for therapists and researchers to assess treatment outcomes and investigate etiology, prognosis, and symptom progression in OCD. In Iran, Dadfar (1997) reported test-retest reliability of 0.85, a total reliability coefficient of 0.84, and a convergent validity coefficient of 0.87 with the Yale-Brown Obsessive-Compulsive Scale.

2.2.2. Obsessive Beliefs

This questionnaire was developed by the Obsessive Compulsive Cognitions Working Group (2003) to evaluate the role of cognitions in the etiology and maintenance of OCD. It includes 44 items rated on a 7-point Likert scale ranging from -3 (strongly disagree) to +3 (strongly agree), with 0 indicating neutral. The scale covers five subdomains reflecting key cognitive dimensions in OCD: general obsessionality (16 items), responsibility and threat estimation (7 items), perfectionism and certainty (10 items), importance of thoughts and control of thoughts (6 items), and the need to perform actions completely (5 items). The 2003 study reported an internal consistency of 0.80 and good test-retest reliability. A subsequent analysis by the Working Group (2005) using factor analysis identified three main components: (1) responsibility/threat estimation, (2) perfectionism/need for certainty, and (3) importance and control of thoughts (Obsessive Compulsive Cognitions Working Group, 2005). In an Iranian sample, Shams (2004) found internal consistency of 0.92 and test-retest reliability of 0.82. Criterion validity assessed with the MOCI was 50%, which was statistically significant (Shams, 2004).

2.2.3. Anxiety

Developed by Beck, Epstein, Brown, and Steer (1988), the BAI consists of 21 items measuring symptoms of anxiety. Each item has four response options reflecting severity: 0 (not at all), 1 (mild), 2 (moderate), and 3 (severe), producing a total score range from 0 to 63. Scores of 0–7 indicate minimal anxiety, 8–15 mild, 16–25 moderate, and 26–63 severe anxiety. The BAI is a self-report inventory designed to assess the intensity of anxiety in adults. Cronbach's alpha for internal consistency was 0.92, and test-retest reliability over one week was 0.75, with item correlations ranging from 0.30 to 0.76. Beck and Clark (1997) reported an internal consistency of 0.93 and a test-retest reliability of 0.75. In Iranian validation studies, Haqayeq (2007) reported a Cronbach's alpha of 0.92 and test-retest reliability of 0.75 over a one-week interval, with item correlations ranging from 0.30 to 0.76 (Haqayeq, 2007).

2.3. *Interventions*

2.3.1. *Cognitive Behavioral Therapy*

In the first session, participants were introduced to OCD, including its definition, lifestyle implications, and the role of suppression in reinforcing compulsive behaviors. Key OCD-related terms were explained, and clients shared their experiences and goals. Homework included filling in monitoring sheets to report obsessive episodes, anxiety intensity, and attentional lapses. The second session involved reviewing homework, providing psychoeducation on the cognitive-behavioral model, and explaining the thought–emotion–behavior cycle and cognitive distortions, followed by a cognitive assignment as homework. In the third session, homework was reviewed, and psychoeducation focused on coping strategies for cognitive distortions, with personalized examples. Homework involved identifying cognitive distortions and completing daily thought records. The fourth session reviewed prior assignments and introduced exposure and response prevention (ERP) alongside physical relaxation techniques. In the fifth session, therapists focused on strategies for preventing obsessive thoughts and rituals through ERP and cognitive restructuring. Clients practiced identifying distorted thoughts and replacing them with more adaptive interpretations.

2.3.2. *Dialectical Behavior Therapy*

The first session began with introducing the treatment structure, goals, and rules. Participants were familiarized with the three states of mind: rational, emotional, and wise mind. In the second session, exercises related to these states were practiced, and mindfulness skills were introduced—specifically the "what" (observe, describe, participate) and "how" (non-judgmental stance, mindfulness, effective action) skills. The third session involved active practice of these core DBT mindfulness skills. In the fourth session, emotion regulation skills were introduced, focusing on the definition and components of emotions. The fifth session continued emotion regulation training by teaching emotion identification and labeling, enhancing emotional control. In the sixth session, skills were reviewed and expanded to include acceptance of emotions—even negative ones—and reducing vulnerability to them. The seventh session introduced distress tolerance skills for crisis survival, such as distraction and self-soothing using the five senses. Finally, the eighth session reviewed all prior content and emphasized crisis management through practical techniques like "improving the moment" and cost–benefit analysis. Skill generalization to real-life contexts was emphasized.

2.3.3. *Data Analysis*

Descriptive statistics were used for initial data examination. To compare group differences, a mixed between-within subjects analysis of variance (mixed ANOVA) with Bonferroni post hoc test was conducted using SPSS software, version 27.

3. Findings and Results

Based on the results in Table 1, the mean scores for anxiety and obsessive beliefs decreased in both experimental groups from pre-test to post-test and follow-up. Among the three groups, the highest mean scores for obsessive beliefs and anxiety were observed in the control group (69.20 and 52.73, respectively), while the lowest mean anxiety score appeared in the CBT group (41.40), and the lowest mean obsessive beliefs score was found in the DBT group (59.13).

Table 1

Descriptive Analysis of Variables

Variable	Sample Size	Stage	Obsessive Beliefs (M)	SD	Anxiety (M)	SD
Cognitive Behavioral Therapy	15	Pre-test	68.46	2.61	52.60	1.05
		Post-test	61.00	1.41	41.40	1.05
		Follow-up	61.00	1.41	41.40	1.05
Dialectical Behavior Therapy	15	Pre-test	69.80	3.57	52.06	0.88
		Post-test	59.13	1.99	41.60	0.82
		Follow-up	59.14	2.00	41.60	0.82
Control	15	Pre-test	69.20	3.48	52.73	0.88
		Post-test	69.20	3.48	52.73	0.88
		Follow-up	69.20	3.48	52.73	0.88

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Following the verification of normality using the Kolmogorov-Smirnov test ($p > .05$), homogeneity of variances using Levene's test, and covariance homogeneity using Box's M test ($p < .01$), a mixed between-within subjects ANOVA was conducted. The results of this analysis are presented in Table 2.

Table 2

Mixed ANOVA for Obsessive Beliefs and Anxiety Across Three Time Points in Three Groups

Variable	Factor	F	df	Significance	Effect Size
Obsessive Beliefs	Group	143.53	2, 42	.001	.77
	Time	143.53	2, 41	.001	.77
	Group × Time	39.23	4, 82	.001	.65
Anxiety	Group	1586.64	2, 42	.001	.97
	Time	1586.64	2, 41	.001	.97
	Group × Time	398.024	4, 82	.001	.95

The results of the mixed ANOVA for obsessive beliefs and anxiety scores indicate that the group differences were statistically significant ($p < .01$). These results show that the implementation of CBT and DBT led to significant changes in anxiety and obsessive beliefs across the three measurement periods: pre-test, post-test, and follow-up ($p < .01$). Moreover, the interaction effect of group × time for both variables was significant ($p < .01$), indicating performance changes across the groups over time.

Based on Table 3, it was shown that pre-test scores for anxiety and obsessive beliefs were relatively similar across the study groups. However, following the application of CBT and DBT in Experimental Groups 1 and 2, a significant reduction in obsessive beliefs and anxiety was observed at the post-test stage, whereas no notable change occurred in the control group.

According to Table 3, at the post-test stage, the DBT group had lower obsessive belief scores than the CBT group with a mean difference of -1.86, although this difference was not statistically significant ($p > .01$). In terms of anxiety, there was no significant difference between the two experimental groups, with a mean difference of -0.20 ($p > .05$).

During the follow-up phase, the treatment effects were maintained in both experimental groups, while in the control group, changes between the post-test and follow-up stages were negligible. Therefore, both CBT and DBT led to improvements in obsessive beliefs and anxiety levels in individuals with OCD compared to the control group. In terms of obsessive beliefs, DBT outperformed CBT.

Table 3

Bonferroni Post Hoc Test for Obsessive Beliefs and Anxiety at Post-Test and Follow-Up Stages

Stage	Variable	Group Comparison	Mean Difference	Standard Error	Significance
Post-test	Obsessive Beliefs	CBT – Control	-8.20	0.89	.001
		DBT – Control	-10.06	0.89	.001
		CBT – DBT	-1.86	0.89	.132
	Anxiety	CBT – Control	-11.33	0.33	.001
		DBT – Control	-11.13	0.33	.001
		CBT – DBT	0.20	0.33	1.000
Follow-up	Obsessive Beliefs	CBT – Control	-8.20	0.89	.001
		DBT – Control	-10.60	0.89	.001
		CBT – DBT	1.86	0.89	.132
	Anxiety	CBT – Control	-11.33	0.33	.001
		DBT – Control	-11.13	0.33	.001
		CBT – DBT	-0.20	0.33	1.000

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4. Discussion and Conclusion

The present study aimed to compare the effectiveness of Dialectical Behavior Therapy (DBT) and Cognitive Behavioral Therapy (CBT) on obsessive beliefs and anxiety in individuals with Obsessive-Compulsive Disorder (OCD). The results demonstrated that both CBT and DBT significantly reduced obsessive beliefs and anxiety, and these therapeutic effects persisted during the one-month follow-up period. However, while both approaches were effective, no statistically significant difference was observed between the two in terms of anxiety reduction. These findings align with prior findings (Afshari, 2020; Amighi, 2023), all of which indicated the efficacy of DBT in reducing anxiety symptoms and maladaptive cognitive beliefs.

Emotion is not a simple phenomenon, and effective emotion regulation approaches must consider the multidimensional and both adaptive and maladaptive nature of emotions (Pekrun, 2014). Therefore, Leahy et al. (2011) emphasized the importance of techniques that address these diverse emotional processes (Leahy, 2011). In line with this, Linehan (1993) developed DBT as a more integrative behavioral approach grounded in mindfulness, balancing change-oriented and acceptance-based strategies (Linehan, 1993). DBT focuses on helping individuals identify, express, and cope with emotions (Fitzpatrick, 2020; Linehan, 1993), set personal goals, monitor goal-directed behaviors, improve problem-solving abilities, and manage suicidal ideation and crisis behaviors, as shown in numerous recent studies evaluating DBT's efficacy in treating emotional difficulties (Fruzzetti & Payne, 2020).

DBT reduces anxiety by targeting its key components: appraisal, sensation, intentionality, affective responses, behavioral tendencies, and interpersonal factors (Leahy, 2011). Mindfulness training teaches individuals not to interpret failure to meet deadlines as personal inadequacy but to accept it as a nonjudgmental experience. Interpersonal effectiveness skills help individuals maintain satisfying relationships. Emotion regulation and distress tolerance skills reduce physical tension and enable emotional management. For adolescents, anxiety is often exacerbated by adjusting to new school environments alongside developmental changes (Duchesne, 2012). DBT skills aid in adolescent adaptation to new environments and internal transitions. For example, mindfulness allows adolescents to approach internal and external changes with nonjudgmental awareness (Baer, 2006), recognizing emotions as natural responses to change rather than threats. Mindfulness also fosters unconditionally accepting connections with new peers, easing the emotional void caused by separating from previous friendships, and enhancing present-focused attention to form new bonds (Navarro-Haro, 2019). Communication training, including assertiveness (Alberti & Emmons, 1990), equips adolescents to express themselves confidently, identify shared interests, and strengthen social ties, thereby increasing belonging and reducing interpersonal conflict. Emotion regulation and distress tolerance reduce school-related anxiety by reinforcing the understanding that anxiety often stems from unrealistic anticipations of future threats (Beckner, 2013).

The results also align with prior studies (Amighi, 2023; Delir, 2014; Hoffman, 2013; Mahdipour Pilahroud & Bayat Paridari, 2024; Rezaei, 2022; Sadeghzadeh, 2024), which consistently demonstrated CBT's effectiveness in reducing anxiety. CBT achieves this by helping clients recognize and modify distorted thoughts and maladaptive behavioral patterns. CBT interventions represent structured efforts to integrate cognitive activities with behavior modification to facilitate therapeutic change, emphasizing cognition's role in emotional and behavioral transformation. CBT is a structured, short-term, problem-focused therapeutic approach that seeks to adjust irrational beliefs (Malcomson, 2007). It combines classical and operant conditioning principles from behaviorism with cognitive approaches within cognitive psychology. While CBT encompasses diverse theories, its unifying feature is the mediating role of cognitive processes in interpreting stimuli and guiding responses. CBT uses behavioral-based language and measurable constructs (Hoffman, 2013; Hofmann, 2013). It helps patients identify, examine, and reframe negative thoughts. The core of CBT is self-help, wherein therapists empower patients to develop the skills necessary to address current and future issues (Huguet, 2016). Ultimately, CBT aims to identify and reconstruct irrational beliefs and self-schemas that contribute to emotional disturbances and maladaptive behaviors (Zachariae, 2016).

Given the findings, both CBT and DBT were effective in reducing anxiety and obsessive beliefs in individuals with OCD. However, DBT was more effective in reducing obsessive beliefs. Therefore, both methods can be considered appropriate, cost-effective, and efficient interventions in psychological treatment centers for managing anxiety and obsessive beliefs in individuals with OCD. Considering the study's limitation to male high school students in District 14 of Tehran, future studies should

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include female participants and other geographic regions to enhance generalizability. Additionally, since this study used convenience sampling, future research should employ more rigorous methods such as cluster or stratified sampling.

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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