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EFFECTIVENESS OF MULTI-DIMENSIONAL GROUP THERAPY ON OBSESSION SYMPTOMS, EMOTION CONTROL, IMPULSE CONTROL AND SELF-COMPASSION IN WOMEN WITH OBSESSIVE-COMPULSIVE DISORDER

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ABSTRACT

The present study aimed to investigate the effectiveness of multi-dimensional group therapy on obsession symptoms, emotion control, impulse control, and self-compassion in women with obsessive-compulsive symptoms. The research method was a pre-test and post-test quasi-experimental design with experimental and control groups. The statistical population of the present study was all women suffering from obsessive-compulsive disorder who were referred to Talieh Salamat Clinic, Tehran in 2021. The purposeful sampling method was used in the present study due to the lack of easy access. Therefore, 30 participants were selected from among the statistical population using targeted sampling and randomly divided into an experimental group and a control group (each group contains 15 individuals). Yale-Brown Obsessive-compulsive Scale by Goodman et al. (1989), the Self-Compassion Scale by Neff (2003), the emotion regulation scale by Williams and Kamles (1977), and the Barratt Impulsiveness Scale by Barratt et al. (2004) were distributed between the two groups. Then, the obsession treatment intervention was implemented in 30 two-hour sessions in the experimental group. The post-test was then performed. Data were analyzed using SPSS (version 24) and ANCOVA. The results of ANCOVA for self-compassion subscales indicated that a significant difference was observed in the components of self-kindness (P=0.005), self-judgment (P=0.029), and mindfulness (P=0.008) between the groups in pre-test and post-test. Also, there is a significant difference in the subscales of depression (P=0.020) and anxiety (P=0.024) of the emotion control variable, between the groups in the pre-test and post-test. None of the impulsivity subscales showed significant differences between the pre-test and the post-test. The treatment of obsession with multi-dimensional group therapy seems to reduce the symptoms of obsessive-compulsive disorder and its accompanying symptoms. Therefore, researchers and therapists are recommended to use this method for their patients. A significant difference was also observed in the obsession scale between the experimental and control groups in the pre-test and post-test (P<0.001).

Keywords: *Emotion control, Impulse control, Intellectual-practical obsession, Multi-dimensional group therapy, Self-compassion.*

INTRODUCTION

Obsessive-compulsive disorder (OCD) is a complex neuropsychiatric syndrome whose main characteristic is unwanted, repeated, and disturbing thoughts (obsessions) as well as repetitive, disturbing, and ritualistic behaviors (compulsions) which the patient does to avoid anxiety by neutralizing compulsions (American Psychological Association, 2013). The disorder can be highly variable in different geographical regions (Rapinesi et al., 2019), with a reported prevalence ranging from 1% to 4% (Jaisoorya et al., 2017). Obsessions are anxiety-provoking, unwanted, and persistent thoughts, as well as impulses with self-incongruent images, in the sense that they are disturbing, distracting, and inappropriate, and do not match the individual's apparent and perceived feelings. Compulsions develop in response to obsessions aimed at reducing distress, involving repetitive behaviors, such as hand washing/cleaning, checking on things, and mental acts like counting (American Psychological Association, 2013). The main feature of these obsessions and compulsions (thoughts and behaviors) is that they are not enjoyable for the affected person, however, the patient continues to ruminate on thoughts and repeat actions to reduce the discomfort (Seli et al., 2017).

According to the abovementioned points, some variables cause the continuation and stability of the symptoms of this disorder besides obsessions and compulsions which consequently increases their treatment resistance. In fact, the main symptoms in patients with OCD and side features such as worry, rumination, and confusion of thoughts and activities cause the person to become severely disturbed, passive, and have a strong reaction (Erhan & Balci, 2017). Patients with OCD are a large part of the clients to counseling centers due to the pressure of the disease and their companions, including the family (Lebowitz et al., 2016)

Self-compassion means that an individual accepts one's failures, defects, and faults (Allen & Leary, 2010). Self-compassion means having a hopeful and understanding attitude towards yourself, instead of a negative attitude by combining three components: self-kindness vs. self-judgment, mindfulness vs. over-cognition, and common humanity vs. isolation (Krieger et al., 2013). Also, this concept does not mean ignoring flaws and weaknesses but being kind to yourself instead of criticizing (Basharpour & Eisazadegan, 2011). The concept increases the ability to deal with failures and means being caring and kind to oneself and having a non-judgmental attitude towards one's shortcomings and failures (Sangani et al., 2021). In general, it consists of generalizing the feeling of self-pity to one's self in times of failure, feeling of inadequacy, or suffering and hardship (Neff & Germer, 2013). The study conducted by Neff and Beretvas (2013) indicated that self-compassion has a strong relationship with mental health. Those with higher levels of self-compassion experience lower levels of depression, anxiety, rumination, and obsession compared to those who lack self-compassion (Warren et al., 2016); also, their job performance, flexibility, optimism, and satisfaction are affected in different dimensions (Sirois et al., 2019).

Impulse control is one of the psychological variables that affects OCD. Impulse control is defined as a predisposition toward rapid and unplanned reactions to internal or external stimuli without considering the negative consequences of those reactions for oneself and others (Stanford et al., 2004). Barratt's theory (1995) is a view on impulse control that has received much attention in recent years. Barratt found three facets that reflect the different components of impulse control by the information from combining medical, psychological, behavioral, and social perspectives.

These three facets include cognitive (the ability to focus on tasks and cognitive instability), affective (including self-control and cognitive complexity), and motor (acting quickly and persistence) (Plichta & Scheres, 2014). Voon et al.'s study (2017) indicated that those with OCD show a higher level of impulse control compared to the control group. Particularly, patients with OCD and a history of tics reported a higher level of impulse control. Beyrami et al. (2011) also revealed that higher levels of impulse control were observed in the experimental groups compared to the control group.

Emotion regulation difficulties are common in almost all patients with OCD. Also, OCD is characterized by a wide range of emotion regulation difficulties, especially fear of emotions or fear of accepting emotions (Yap et al. 2018). Emotion control is also another component of emotion regulation proposed by William et al. which they have defined as expressing emotions only as an emotion. In other words, the more a person's emotional control is, the person does not evaluate emotions as scary and allows them to be expressed (Badakhshan et al. 2021). Emotion control does not mean preventing an emotional state, but it means experiencing an emotion in its true form and not avoiding it (Bond and Bunce, 2003).

Due to the high prevalence of OCD, several psychological therapy approaches have been used in addition to medication, including psychoanalysis, acceptance and commitment therapy, and family therapy (Mckay et al. 2015).

One of the biggest obstacles in treating those with OCD is that relatively few therapists have completed the CBT course and know the necessary strategies to treat these patients (Janbozorgi & Rajezi, 2011). Also, the findings consider the quality of the therapist's work and therapeutic efforts as the most influencing factors in treatment (As quoted by Janbozorgi & Rajezi, 2011). Therefore, group therapy can be a suitable alternative for treating these people who need specialized treatment. In this method, the patient is not just a passive receiver, and the method is useful for breaking patients' treatment resistance (Mokameli et al., 2005). Materials presented in the group therapy are effective in increasing patient compliance using group peer influences (Halland et al. 2010; quoted by Bulut & Subasi, 2020).

Therefore, according to the mentioned cases, the present study aimed to investigate the effectiveness of multi-dimensional group therapy on obsession symptoms, emotion control, impulse control, and self-compassion in women with OCD.

MATERIALS AND METHODS

The research method was a pre-test and post-test quasi-experimental design with experimental and control groups. The statistical population of the present study was all women suffering from obsessive-compulsive disorder who were referred to Talieh Salamat Clinic, Tehran in 2021. The purposeful sampling method was used in the present study due to the lack of easy access. Therefore, 30 participants were selected from among the statistical population using targeted sampling and randomly divided into an experimental group and a control group (each group contains 15 individuals). The inclusion criteria are 1) being a woman, 2) suffering from OCD, 3) having at least a diploma, 4) not participating in other treatment interventions, and 5) not suffering from other mental diseases. The exclusion criteria also included 1) absence of more than three sessions and 2) non-observance of the rules of group therapy.

With all psychiatrist-, clinical psychologist- and self-reported OCD patients who wanted treatment and participated in the study, the SCID-5 for major disorders and the SCID-5-PD for personality disorders were administered by the psychiatrist and psychologist. It was taken clinically and after determining that it has entry and exit criteria, Yale-Brown instruments (for obsession and compulsion), Self-compassion scale, the emotion regulation scale, Barratt impulsiveness scale were taken.

Tools

- Structured clinical interview for DSM-5 (SCID-5-RV) disorders

First et al. [1997] have developed this tool. SCID-5 is a semi-structured interview designed to increase the validity and reliability of previous versions of SCID. Mohammadkhani et al. [2020] have validated SCID-5 in Iran. SCID-5 has acceptable formal validity. Internal consistency was obtained using Cronbach's alpha for all disorders between 0.95 and 0.99. Reliability of retest after two weeks was between 0.60 and 0.79, and kappa reliability was 0.57 to 0.72.

- Structured Clinical Interview for Personality Disorders based on DSM-5 (SCID-5-PD)

First, et al. developed the assessment of 10 Axis II personality disorders in DSM-IV and [1997]. As for the reliability of SCID-II, First et al. [1997] have conducted some studies, and all have shown high reliability of this test. In Iran, the research of Bakhtiari [1379] obtained the content validity of the translated version of the test. SCID-5 has 116 questions that Ghamkhar Fard, Pourshahbaz, Anderson, and Boland [2021] have validated SCID-5 for DSM-5 based personality disorders in the Iranian population. Internal consistencies (Cronbach's alpha and interrater correlation) were obtained for the number of symptoms of each disorder. Cronbach's alpha for all personality disorders was between 45% for schizoid personality disorder and 75% for antisocial personality disorder.

Yale-Brown Obsessive-compulsive Scale (Y-BOCS): This scale was designed by Goodman et al. in 1989. It has a total of ten items, five of which are on obsessions and five on compulsions (Goodman et al. 1986). The total Y-BOCS score is the sum of items 1 to 10 (range, 0 to 40). You should sum the numbers that are written next to the answers to questions 1 to 10 and you have checked one of them to score in this questionnaire. If the subject's answer to this question is no, mark the answer no for questions 1, 2, 3, 4, and 5 and go to question 6. If the subject's answer to this question is no, mark the answer to questions 7, 8, 9, and 10 as no. Asadi et al. reported an interrater reliability of 0.98, an internal consistency coefficient of 0.89, and a retest reliability coefficient of 0.84 for this scale within two weeks. Also, its diagnostic validity was obtained at 0.64 and 0.59 with the Beck Depression Inventory and Hamilton Rating Scale for Depression, respectively (Asadi et al., 2017).

Self-Compassion Scale: A 26-item self-report scale designed by Neff in 2003 to measure the level of self-compassion. The scale was designed to measure the three main components of self-compassion on separate subscales of self-kindness/self-judgment, common humanity/perceived isolation, and mindfulness/over-identification. Such as how kind (not critical) a person is to oneself and considers one own experience as part of others' experiences, and refrains from exaggerating experiences. Therefore, this scale determines the open view of issues and the

quality of awareness, which is the second form of mindfulness. It is scored on a five-point Likert scale, from 1 (almost never) to 4 (almost always). A higher score means more self-compassion (Neff, 2003). The study conducted by Neff reported good validity and reliability for the scale. The reliability was obtained at 0.92 using Cronbach's alpha method. Also, each of the subscales had good internal consistency (from 0.75 to 0.81). In addition, the test-retest reliability was reported to be 0.93 at a two-week interval (Neff, 2003). The Cronbach's alpha coefficient of this scale was reported as 0.84 in the study of Ghorbani et al. in Iran (Ghorbani et al., 2011).

The emotion regulation scale: This scale was invented by Williams and Kamles (1977) and is a tool to measure individuals' control over their emotions. The scale includes 42 questions with four subscales anger, depression, anxiety, and positive affect, which are on a 7-point Likert scale. In a sample of students, the internal and test-retest validity of the test for the total score of the scale was 0.94 and 0.78 and for the subscales of anger was 0.72 and 0.73., depression was 0.91 and 0.76, anxiety was 0.89 and 0.77, and positive affect was 0.84 and 0.68, respectively and its discriminant and convergent validity were confirmed (Williams, 1997). In the study conducted by Dahesh (2009), the Cronbach's alpha of the whole questionnaire was 0.84, and the subscales of anger, positive emotion, depression, and anxiety were 0.53, 0.60, 0.76, and 0.64, respectively which indicates the appropriateness of this scale for samples in Iran.

Barratt Impulsiveness Scale: This 30-item self-report instrument (11th edition) was introduced by Ernest Barratt et al. in 2004 (quoted by Adalati & Yazdi, 2006). This tool is based on Barratt's theory, which measures three subdomains of impulsivity (attention, motor, and non-planning). The questions are four options from rarely to almost always, and the highest score will be 120. The validity and reliability of the Persian version of this questionnaire have been conducted in the study of Ekhtiari et al. 2008, the result of which indicates that this questionnaire has good validity and reliability.

Multi-dimensional Group Therapy for Obsessions

Multidimensional group therapy with an emphasis on Lazarus' multimodal therapy is a structured program for the treatment of OCD, which is based on the CBT program (Clarke, 2004), Lazarus' multimodal therapy (2008), Palmer and Derridan (1995) and Janbozorgi and Nouri (2009). This type of therapy has been compiled in a group form according to the Iranian Islamic culture (Janbozorgi, 1999). Janbozorgi first used this program for generalized anxiety disorder (GAD), with and without religious orientation in 12 sessions. This program is designed to control OCD in 30 sessions. The reason for increasing the number of sessions was clinical experience and the opinion of his colleague (Janbozorgi and Rajezi, 2018). The main structure of treatment remained based on Lazarus' multimodal therapy. Changes were made in the first program to apply interventions related to spirituality and religion (Janbozorgi, 1999), which was able to significantly control anxiety in different studies (Janbozorgi et al., 2009; Janbozorgi et al., 2010). In the present study, seven sessions were used to increase awareness and break the patient's treatment resistance. Also, the treatment is divided into two parts (1) behavioral control of incontinence (obsession) and (2) multidimensional reconstruction (including cognitive, visual, communication, spiritual, emotional, biological, and lifestyle interventions), it was divided based on the structural profile of the target and the dimensional profile to control the obsessions and internalize the changes created, and 10 sessions were dedicated to it. Finally, a

30-session program was set, which was sometimes increased to 35 sessions based on the progress and level of individual practice of the members **(Table 1)**.

The content of the group therapy was designed by Janbozorgi and Rajezi Esfahani (2011) and based on Lazarus' multimodal therapy (1997, 2008), and its validity was confirmed by experts. Also, this treatment method has been registered in Iran's clinical trial (138812103457N1) and has an ethical code (87-01-102-5969-1058).

This intervention method was presented to the cognitive-behavioral therapy group as shown in **Table 1**.

Table 1. The multi-dimensional therapy used in the present study (Treatment program for OCD, Janbozorgi & Rajezi, 2019)

Stages	Sessions	content
Start: motivation and increasing awareness	1-7	1. Using group therapy strategies to increase trust and group performance 2. Getting to know obsession patterns 3. Group conceptualization and formulation by preparing a structural and dimensional profile (within the cultural framework) 4. Coordination of the group with the treatment logic and dimensions of the intervention 5. Group investigation of the interaction of dimensions, preparation of profiles, and preparation of the group for intervention 6. Beginning of relaxation training 7. Correcting superficial thoughts about your obsession (especially religious feedback)
Transition: de-stressing, managing resistance, preparing for treatment	8-12	1. Check the resistances 2. Dissolution of resistances 3. Starting treatment focusing on exposure and response prevention and de-stressing 4. Definition and classification of goals
Work: Working on goals with multidimensional strategies aimed at controlling obsessions	11-12 to 20-25	According to the structural profile and formulation of each session, while following the core strategies, in various dimensions, various interventions are used to help progress the

		work. This phase continues until everyone achieves a minimum of 80% success.
Before the end: stopping obsessive thoughts, changing psychological cognitions, replacing efficient behaviors, generalization	25-30	1. Start working on mental obsessions 2. Changing core knowledge 3. Replacement of efficient behaviors 4. Generalization
End: Consolidation of treatment	30 and more	1. generalization 2. Prevention of return

In the present study, ethical standards including obtaining informed consent, and ensuring confidentiality were observed. Also, the participants were free to provide individual information and withdraw from the research at any time.

This session was held separately for the control group and they were asked to stay in touch with the psychotherapist until the end of the waiting period to receive the treatment afterwards. Due to the long examination period, a one-hour session on the topic of "New findings about non-pharmacological treatments" was organized to keep the control group motivated at the same time as the periodical examination.

Data analysis was conducted in descriptive statistics and inferential statistics. Frequency, percentage, mean, and standard deviation were used in the level of descriptive statistics. At the level of inferential statistics, the Kolmogorov-Smirnov test was used to check the normality of the data, and the Levene's test as well as the assumption of the homogeneity of regression slope by examining the interaction effect of group pretest in the regression model were used to check the homogeneity of the variances. Finally, one-way ANCOVA was used. Data analysis was conducted using SPSS (version 24). A p-value of 0.05 is considered statistically significant.

RESULTS AND DISCUSSION

A total of 30 subjects with an average age of 35 and a standard deviation of age of 7.2 participated in this study. Also, 37.5% of the subjects had a diploma, 12.5% an associate degree, 37.5% a bachelor's degree and 12.5% a master's degree.

In **Table 2**, the descriptive characteristics of scores of self-compassion, emotion control, and impulse control and their subscales in the pre-test and post-test phases, as well as the average difference between the two test phases, in the experimental and control groups are presented.

Table 2. Descriptive characteristics of the difference in the change of the subscales of the variables by separating the two groups

Variable	Experimental Group		Control Group	
	Pre-test	Post-test	Pre-test	Post-test

	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Self-kindness	14.5	5.1	18.1	4.3	14.2	4.3	14.6	4.1
Self-judgment	13.5	3.1	11.1	3.8	12.5	3.2	12.9	3.4
Common humanity	12	4.3	11.3	3.1	13.2	3.1	13.5	3.7
Perceived isolation	12.8	2.1	12.3	2.2	13.2	3.5	12.8	3.6
Mindfulness	14.1	3.3	16.3	4.3	14.8	3.7	14.4	3.9
Over-identification	12.1	4.3	12.8	3.3	12.6	4.1	12.9	4.2
Anger	28.5	5.5	27.7	5.7	26.4	5.2	27.2	5.6
Depression	29.7	5.6	27.4	5.4	27.2	4.9	26.8	4.6
Anxiety	45.3	5.9	43.8	5.3	44.8	6.1	44.2	6.3
positive affect	38.7	5.3	40.1	5.2	35.6	5.7	35.9	5.1
Attention	16.6	3.1	16.3	3.9	17.1	3.4	17.5	3.6
Motor	19	1.5	19.3	1.7	17.8	1.3	18.3	1.8
Non-planning	23.1	4.1	23.2	4.2	21.4	4.2	22.5	3.8
Obsession	24.7	7.6	8.7	5.6	23.1	6.3	22.4	7.1

Table 2 shows the average scores of the experimental and control groups before and after the implementation of the OCD treatment plan. According to the above table, the scores of the experimental group have improved compared to those of the control group in all three variables of self-compassion, emotion control, and impulse and obsession control.

Before implementing MANCOVA, the Kolmogorov-Smirnov test and Levene's test were used to check compliance with the necessary assumptions. The Kolmogorov-Smirnov test for the distribution of research variables in the post-test stage showed that the assumption of normality was not rejected ($p<0.05$). Levene's test was used to check the homogeneity of error variances. The results of Levene's test indicated that the assumption of homogeneity of variances was not rejected ($p<0.05$). Also, the homogeneity of the regression slope regarding the non-significance of the group-pretest interaction effect was not rejected ($p<0.05$). Therefore, there were necessary presuppositions to perform one-way ANCOVA.

Table 3. Covariance analysis test in the subscales of self-compassion, emotion control, impulse control, and obsession

Variable	SS	MS	F	Df1	Df2	α	Eta
Self-kindness	105/1	105/1	9/6	1	28	0/005	0/28

Self-Judgment	45/1	45/1	5/3	1	28	0/029	0/18
Common humanity	2/1	2/1	0/491	1	28	0/49	0/020
Perceived isolation	2	2	0/99	1	28	0/328	0/04
Mindfulness	40/5	40/5	8/2	1	28	0/008	0/25
Over-identification	4/5	4/5	2/1	1	28	0/166	0/078
Anger	0/18	0/18	1/1	1	28	0/322	0/038
Depression	171/1	171/1	6/1	1	28	0/020	0/19
Anxiety	78/1	78/1	5/7	1	28	0/024	0/18
positive affect	66/1	66/1	3/5	1	28	0/072	0/11
Attention	0/5	0/5	0/16	1	28	0/689	0/006
Motor	1/1	1/1	0/60	1	28	0/445	0/022
Non-planning	0/12	0/12	0/023	1	28	0/881	0/001
Obsession	2048/1	2048/1	62/1	1	28	<0/001	0/68

In **Table 3** the results of ANCOVA for subscales of self-compassion show that a significant difference was observed in the components of self-kindness (P=0.005), self-judgment (P=0.029), and mindfulness (P=0.008) between the experimental and control groups in pre-test and post-test. Also, in the subscales of depression (P=0.020) and anxiety (P=0.024) of the emotion control variable, there is a significant difference between the two experimental and control groups in the pre-test and post-test. However, no significant difference was observed in any of the subscales of impulsivity between the pre-test and post-test. Also, there is a significant difference in the obsession scale between the two experimental and control groups in the pre-test and post-test (P<0.0).

CONCLUSION

The present study aimed to investigate the effectiveness of multidimensional group therapy on obsession symptoms, emotion control, impulse control, and self-compassion in women with OCD. The results of ANCOVA showed that the intervention for OCD improved the scores of emotional control in women with OCD. This study showed a significant improvement in the scores of emotion control of the participants compared to the beginning of the study (p<0.05).

In explaining the intervention of multidimensional group therapy on obsessive-compulsive symptoms, it can be said that the therapist tries to prepare patients to start the treatment process by motivating and alerting them in the initial sessions. This allows patients to get the most out of treatment in later stages. Then, patients are moved toward the ultimate goal of reducing

obsessive-compulsive symptoms in the transition stage by de-stressing, managing resistance, and preparing for treatments. In the next step, multidimensional strategies were used to reach the goal of controlling compulsions. The symptoms of obsessions are reduced in patients by using various methods such as behavior analysis, anxiety management training, mental health awareness, and practical exercises. Finally, the symptoms of obsession will significantly decrease by stopping obsessive thoughts, changing psychical cognition, replacing efficient behaviors, and generalization (Lazarus, 2008; Janbozorgi & Rajezi, 2011).

In explaining the effectiveness of multidimensional group therapy for OCD in controlling emotions, it can be said that this therapy helps women with OCD to accept their uncomfortable thoughts and feelings without judgment or evaluation by establishing a different communication style with themselves and using a different method of information processing. Also, they believe that part of these changes can be due to the mechanisms of action proposed in the observational method, such as confrontation, acceptance, relaxation, desensitization, changing the relationship with thoughts, and cognitive emotion regulation (Hosseini et al., 2022). Also, the results of the ANCOVA showed that the intervention for OCD failed to affect the scores of impulse control in women with OCD.

The ineffectiveness of treatment intervention on the scores of impulse control in women with OCD may be due to various factors. These factors can include a mismatch between the type of treatment intervention and the type and intensity of obsession. Also, some may have biases towards treatment, and non-adherence to treatment will prevent their recovery. Some obsessive-compulsive treatments, including antidepressants, may have side effects that impair concentration and impulse control. According to these factors, the reason for the ineffectiveness of treatment intervention on impulse control may be different in women with OCD.

Also, the results of the ANCOVA test showed that the intervention for OCD improved the scores of self-compassion in women with OCD. This study indicated a significant improvement in the scores of self-compassion of subjects compared to the beginning of the study ($p<0.05$).

In explaining these findings, it can be said that the treatment of obsession emphasizes the fact that thinking processes are as important as environmental influences. Based on this, this treatment method, which is a combination of insight and cognitive-behavioral therapy and the use of exposure and response prevention, helps those with OCD avoid distorted thinking patterns by using regular discussions and organized behavioral tasks and change dysfunctional behaviors. Obsession treatment intervention is effective in creating and increasing capabilities such as decision-making, motivation to accept responsibility, positive communication with others, happiness, self-esteem, problem-solving, self-discipline, self-sufficiency, and mental health (Epstein & Zheng, 2017). Based on this, the intervention of obsession treatment reduces the psychological components of trauma in people with OCD by controlling and regulating emotions and feelings, controlling mental pressure, establishing effective communication, and self-control, and on the other hand, improving self-compassion using self-efficacy. Obsessive-compulsive therapy usually includes anxiety reduction techniques. Self-compassion also improves by reducing anxiety and women can perform at their best in different situations. Also, women gain more self-confidence by progressing in treatment and acquiring the skills to deal with obsessions. This self-confidence can improve scores of self-compassion. Finally, women can

focus more on their relationships, work, and other important life activities by reducing the intensity and impact of obsession on daily life. This improvement in quality of life can also improve the scores of self-compassion (Wells et al., 2001).

One of the limitations of this study is the sample which only included women who reffered to Talieh Salamat Clinic in Tehran. Generalizing the results to other groups such as those who do not volunteer to receive these services, the group of hospitalized patients, and men is not easily possible. Also, not having a follow-up is one of the other limitations, therefore, it is suggested that future researchers consider follow-ups to measure the long-term effect of the intervention. It is also suggested that psychologists and clinics use this method for their patients with OCD.

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