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ACCEPTANCE AND COMMITMENT THERAPY WITH ISLAMIC ASPECTS AS A TREATMENT FOR SCRUPULOSITY IN A CASE STUDY

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ABSTRACT

This study examines the compatibility of acceptance and commitment therapy (ACT) with religious aspects of scrupulosity and evaluates it in a case study. A mixed-method was used to comply with the intervention protocol; qualitative and quantitative study. In the qualitative section, religious sources were used to examine verses and hadiths' formal and content validity. Then the verses were extracted, and narrations related to ACT components were given to experts by the Delphi method. In the next step, CVI and CVR of verses and narrations were obtained, after that the adapted model based on Twohig's (2004) protocol in 22 to 25 sessions was used. In this stage, a "case study" from April 2020 to September 2020, as a quasi-experimental pre/post test with the sample at convenience, was considered and implemented on an Iranian patient with scrupulosity. The client received treatment. For evaluation, the Yale-Brown Obsessive-Compulsive Disorder Scale (Y-BOCS), the Beck Depression Inventory-II, the Performance Scale (WHODAS 2.0), the Kugler and Jones Guilt Feeling Inventory, Penn Scrupulosity Questionnaire, and Religious Beliefs Questionnaire was used. We compared the total score of the pre-tests and post-tests. The outputs showed that the severity of the symptoms of obsessive-compulsive disorder has decreased, and the scores of other questionnaires have decreased. Treatment process acceptability was high. The results showed that ACT with the religious aspects has good efficacy.

Keywords: *Acceptance and commitment therapy, Islamic aspects, Scrupulosity, Case study.*

INTRODUCTION

Obsessive-compulsive disorder (OCD) is mental, practical, or both (American Psychiatric Association, 2014). According to the latest statistics in 2012, 5.1% of the people of 15 to 65 age in Iran suffer from obsessive-compulsive disorder (Rahimi Movaghar, *et al.*, 2015), which is higher than the annual global prevalence. The highest percentage (50% to 80%) of practical obsessions in Iran is manifested in its religious content, especially impurity, purity, and washing (Fata & Bolhari, 1999).

One clinical presentation of OCD which is well known to therapists but is relatively rare in the experimental treatment literature has been described as scrupulosity (Abramowitz & Hellberg, 2020). Scrupulosity means fear of sin where it does not exist. Common religious obsessions include recurring suspicions that a person has committed sins or moral transgressions by

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mistake or without realizing it; aggressive and holy or blasphemous thoughts and images (Abramowitz & Hellberg, 2020), or a person with scrupulosity may be afraid of contamination and participate in religiously themed disinfection ceremonies, such as over-cleaning after bathing before prayers. Thus, scrupulosity is characterized as a group of nuclear fears associated with any subtype of OCD symptoms (Siev & Huppert, 2016).

The severity of OCD in people with scrupulosity is higher than other subgroups of this disorder (McIngvale *et al.*, 2017; Lee *et al.*, 2018). People with scrupulosity have a lower prognosis than other forms of OCD and are more likely to resist treatment (Alonso, 2001; Ferrão *et al.*, 2006). The treatment of scrupulosity is difficult because these people may see the symptoms of their disease as a religious aspect and not a psychiatric disorder (Huppert & Siev, 2010). On the other hand, clients with this disorder may identify their therapist as someone who does not have the ability and power to observe its religious aspects (Ciarrocchi, 1995; Greenberg, 2008).

Dehlin, Morrison, and Twohig (2013) state that although scrupulosity is highly prevalent and clinically distressing, little attention has been paid to its etiology and treatment.

Among the third wave therapies, acceptance and commitment therapy (ACT) is one of the effective treatment strategies for obsessive-compulsive disorder (Hayes *et al.*, 1999; Hayes *et al.*, 2011). ACT focuses on promoting behavioral changes to increase the quality of life through the performance of the inner experience (Twohig, 2009).

Abramowitz believes that it is necessary to make subtle modifications to traditional treatment models to treat people with religious obsessions that are more severe than other subtypes of obsessions (Abramowitz, 2001). There has been a lot of research in the cognitive-behavioral approach, exposure and response prevention (ERP) to religious aspects (Mohamad Arip *et al.*, 2018). In Iran, we can refer to Akuchekian *et al.* (2017) applied religious CBT teachings to treat patients with scrupulosity, which has been effective. Ramezani (2013) investigated the effectiveness of integrated cognitive-behavioral therapy based on religious (Islamic) aspects in scrupulosity with the content of impurity and purity. The findings indicate that integrated treatment has been effective.

In general, no research has been done with the ACT integrated model for religious obsessive-compulsive disorder. This research aimed to adapt the ACT protocol with religious content for treating clients with scrupulosity. To adjust the intervention protocol, we used the integrated method of sequential processes (Grove *et al.*, 2012). We conducted a qualitative study (review) to examine the formal and content validity of verses and hadiths in the first stage. In the second stage, we tested the effectiveness of the acceptance and commitment adapted treatment protocol with religious content through a pilot study with a client with religious OCD from April 2020 to September 2020.

Method in the Review and Qualitative Stage

In this section, to identify verses and narrations consistent with the components of ACT, we used religious sources with the guidance of a religious advisor (Quran Karim; Majlisi, 1983; Al-Kulayni, 1985; Tamimi, 1988; Al- Sharif al- Radi, 1991; Qara'ati, 1995). We extracted Quranic verses, narrations, hadiths, anecdotes, and stories that were more closely related to the concepts of ACT and better explained the components of ACT. We used the components of this treatment as keywords. We continued the collection of relevant material until the newly obtained

information was repetitive. We prepared verses and narrations related to each ACT component. After preparing about 200 verses and narrations, the researcher used the views of experts in both psychology and religion to complete the study and obtain formal validity. They include 10 people: 4 psychologists, 1 psychiatrist, 4 clerics, and a specialist in Quranic software. Finally, we selected 38 verses and narrations. At this stage, to obtain CVI and CVR of verses and narrations, we selected 15 experts as members of the Delphi team in psychology and religion who were familiar with acceptance and commitment therapy and had a religious approach. We sent CVR and CVI sheets. We calculated the content validity ratio (CVR) to check a verse or narration (Cook & Beckman, 2006). As for the Lawshe table (to determine the minimum value of the index), if the obtained number is greater than 0.49 (based on the evaluation of 15 experts), it indicates that the verse or narration with a statistically significant level ($P<0.05$) has been necessary and important (Lawshe, 1975).
We used Waltz and Basel method to determine CVI.

Table 1. CVI (Content Validity Index) and CVR (Content Validity Ratio) of several verses and narrations with which acceptance and commitment therapy is consistent

Components	Some relevant verses & narrations	CVI	CVR
Acceptance	1. Imam Ali says: Whenever hardship and suffering befall you, sit in front of it because your standing against it increases that suffering. Wisdom 175 Nahj al-Balaghah	1	1
	2. (Insharah, 1) Have we not opened your chest for you?	0.93	0.86
Cognitive defusion	1. (Asra', 36) And do not follow what you do not know.	0.93	0.73
	2. The Holy Prophet (PBUH): The worthiest people give up what is meaningless and useless. (Nahj al-fasaha)	1	1
Being in present	1. Imam Ali: Yesterday passed, and you are unsure about tomorrow; consider today as booty with good deeds! (Ghorar al-hekam va dorar al-kalem.	1	0.86
	2- (Abas, 24) So man should look at his food with reflection.	1	1
Values	1. (Ghafer, 44) I entrust my work to God. God is the Seer of [His] servants.	1	1
Committed action	1. (Fussilat, 30). Those who say, "Our Lord is God," then stand firm, the angels will descend upon them (and they say): Fear not, nor grieve, and be happy for the Paradise we promised.	1	0.86
	2. Every human being depends on his actions. (Toor, 21)	1	1
Self- as-context	1. (Hadid, 23). Do not grieve over what you have lost, and do not rejoice over what He has given you.	1	0.6
	2. Imam Ali: If you remain, sorrow will not remain.	1	1

Qualitative Findings

The results obtained from CVI and CVR showed that out of 38 verses and narrations, 28 verses and narrations had a CVI score higher than 0.79, and a CVR score higher than 0.49. We did not use other verses or narrations in this protocol. After this stage, we designed a draft of the adapted

protocol based on the 8-session ACT protocol for patients with Twohig obsessive-compulsive disorder (Twohig, 2004). Supervisors (clinical psychologist) and counselor (psychologist and clergyman) reviewed and finalized this draft.

Methods and Materials in Quantitative Phase

At this stage, we performed the pilot study. This research is a quasi-experimental design of simple intermittent time series (A-B) and single case. For this purpose, by sampling at convenience from people referring to the counseling and psychotherapy center in Tehran, we selected by interview and screening a person who had an obsessive-compulsive disorder of impurity and purity. After the initial evaluation for admission to the treatment, we obtained written consent from her to participate in the study. Criteria for inclusion in the study were a diagnosis of obsessive-compulsive disorder based on DSM-5 through a diagnostic interview with a psychiatrist or at the discretion of a clinical psychologist based on SCID-5-RV test results, having impurity and purity content in obsessive-compulsive disorder, not receiving psychological treatment for at least one month before entering the study and adherence to religion. The exclusion criteria were the existence of symptoms of psychotic disorders, substance abuse, having major disorders other than anxiety disorders, MDD (Major Depressive Disorder), Dysthymia, having severe personality disorders at the discretion of a psychiatrist based on SCID-5-PD results, having serious suicidal thoughts, any changes in psychiatric medication over the past 30 days, or a plan to change the current administration during treatment.

The client was a 37-year-old woman with an MSc degree, single and housewife; our prepared protocol was performed on her as a single case study. We performed this stage to test the efficiency of the adapted protocol. During the investigation, we used the checklists set up to evaluate the process and the protocol's content from the client's perspective. During the sessions, some items were moved in the protocol to communicate well with the protocol and the process. Due to the limiting conditions caused by covid-19 disease, we conducted the study both in the clinic (when the city was yellow in prevalence) and absent (when the city was orange and red in prevalence) online and by video.

The project's lead researcher, who had been trained in acceptance and commitment therapy for a year and a half, held 22 sessions over 5 months, one to two sessions per week, and under the supervision of an associate professor of clinical psychology specializing in obsessive-compulsive disorder. We took Pre-test and post-test. **Table 2** shows the number of sessions, the structure of the sessions, and their content.

Table 2. Structure and content of treatment sessions

Sessions	
1 & 2	Introducing the structure of treatment sessions, explaining the confidentiality of the content of the session and exceptions, conditions of participating in treatment sessions, taking a history of client: general evaluation of client (physical-psychological-social-religious) and the process of disorder formation, examining the comorbidity of the disorder (also SCID-5-RV and SCID-5- PD based on DSM-5), evaluation of the religiosity of the client based on the Life Image Questionnaire (religious attitude section), explanation of the ACT treatment model and metaphor of two mountains Homework: reading the prepared booklet on OCD

3	Execution of Y-BOCS in collaboration with a psychologist. Homework: Completing worksheet of short-term and long-term effects of OCD in life
4	Performance assessment, examining patient's reactions to the previous session, assessment of homework, explaining control strategies. Homework: Clients should write about the types of controllers they have experienced to reduce their OCD.
5	Continuing the discussion of controlling, measuring performance, examining the patient's reactions to the previous session, reviewing the assignment, explaining the creative hopelessness. The metaphor of digging a hole, the metaphor of a tug-of-war with a giant, the metaphor of falling in love, and the metaphor of a cream cake to explain the avoidance of excitement, paying attention to the examples of client about the types of controllers. Homework: Doing the worksheet to find the kinds of control strategies
6 & 7	Explaining willingness, measuring performance, examining patient's reactions to the previous session, reviewing homework, explaining willingness, compassionate hand technique, explaining committed action. Homework: Read the willingness section of the book of ACT.
8	Mindfulness training: measuring performance, examining patient's reactions to the previous session, reviewing homework, explaining mindfulness exercises, verses, and narrations related to being in the present, hourglass breathing exercises, voice and thought exercises, Practicing mindfulness with prayer. Homework: Mindfulness exercises
9	Performance assessment, examining patient's reactions to the previous session, assessment of homework, stair metaphor, explanation of exposure and response prevention, verses and narrations about exposure, a reminder of the topic of committed action to perform exposures. Homework: Performing low-intensity exposures using the ACT method
10	Performance assessment, examining patient's reactions to the previous session, assessment of homework, introducing the self- as- context and cognitive defusion, practicing numbers, chess metaphor, the metaphor of demons on a boat, pickling, pickling, pickling exercise, observing the self exercise, verses and narrations about self as- context, and cognitive defusion. Homework: Practice observing self, practicing mindfulness, doing low-intensity exposures.
11	Performance assessment, examining patient's reactions to the previous session, assessment of homework, re-formulating language conventions, practicing watching your thoughts in the presence of God, verses, and narrations about self as a context. Homework: mindfulness exercises, using examples from in-house sessions for defusion.
12 & 13	Performance assessment, examining patient's reactions to the previous session, assessment of homework, teaching religious rules in Islam related to scrupulosity, Homework: Mindfulness exercises, exposure and response prevention with low intensity
14	Performance assessment, examining patient's reactions to the previous session, assessment of homework, review of verses related to cognitive defusion and superstitious thoughts.

	Homework: Practicing mindfulness, exposure and response prevention, watching the metaphorical short film appreciation of the mind
15	Performance assessment, examining patient's reactions to the previous session, assessment of homework, explanation of values, the metaphor of 80th birthday, related verses, and narrations. Homework: Like the previous session
16	Performance assessment, examining patient's reactions to the previous session, review of homework, committed action, related verses, and narrations, exposure and review of the integrated model in performing exposures, explanation of therapeutic barriers Homework: Like the previous session
17-25	Performance assessment, examining patient's reactions to the previous session, review of homework Homework: Like the previous sessions

Conceptualization of the Case

Ms. L, a girl in her mid-30s with an MSc degree, single, currently unemployed, living with her family, came to the clinic for religious obsession. She has suffered from an obsession for about 14 years. She stated that she had already suffered from anxiety and had always endured a lot of stress during her studies. During these 14 years, she has been treated with drugs two or three times and has been forced to stop due to the side effects of the drugs. She has been taking 10 mg of citalopram a day for a year. In the family history, her sister and some of her father's relatives suffered from obsession. Some of her symptoms, according to the Yale-Brown 58-Question Questionnaire, are her fear of being touched by something sharp and causing blood to flow (even small touch of a needle makes him feel disgusted), afraid of hurting others, fearful of speaking Surah Al-Jinn and having annoying thoughts that have the content of religious without having any control over them. For performing many religious rituals such as prayer, she has many rules for purity and clean clothes, many rituals for washing after defecation that makes her stay in the bathroom for more than 15 minutes. Because she thinks that urine is secreted into his legs, face, and mouth, and if she speaks, his saliva will be secreted, and impurity will spread everywhere. When performing ablutions, she must first purify the toilet and then perform ablutions. She doubts a lot in the rak'ats of prayer, and despite the seal of prostration counter, she still doubts. During menstruation, she thinks that blood impurity is transmitted from her to different places by sweating. She is very careful not to let this transmission happen. She considers her quilt fuzz and mattress to be contaminated and impure due to her use during menstruation without seeing blood. She washes her hands many times to cleanse herself of impurity. She performs some superstitious rules for removing obsessive thoughts. She has a lot of confidence and often asks the offices of imitation authorities to ensure her water and rinsing, but she is still not satisfied. She often thinks about the utensils of her room that they have become impure due to contagion, and she reluctantly uses them or tries to rinse them.

In her behaviors, there is a lot of avoidance of touching things that she considers impure. She fights them a lot to get rid of obsessive thoughts. She behaves superstitiously when placed together about certain numbers, such as 21, 5, 8, and 3. She recently had a class and was having a hard time with student tuition because she was worried that she would make a miscalculation

and owe it to others. Interpersonal relationships with family members are difficult because of the many manners she has. She has abandoned the jobs she has gained so far due to obsession. She does not have suicidal thoughts; we can describe her case formulation as having no desire to have unpleasant feelings, thoughts, and bodily sensations, and her acceptance in this field is weak. She considers her obsessive thoughts real and therefore engages in superstitious behaviors or compulsions such as washing and has cognitive fusion with her views. She spends most of her time in conflict with the past and its problems or worries about the unknown future. She does not have cognitive flexibility and has a lot of behavioral avoidance. Ms. L had issues with these components and had difficulty experiencing emotions, thoughts, and bodily sensations. She was weak in being able to see herself apart from views. The client was satisfied with the changes resulting from the treatment sessions.

Research tools

1. Questionnaire for Measuring Religious Attitudes

To assess the extent of religious attitudes in this research, we used a part of the Life Image Questionnaire (religious attitude section). Dolatshahi *et al.* (2016) have compiled the construction and validation of the 95-item National Life Image Scale. The relation between the main variables of research showed that there is a significant relationship between the components.

2. 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- RV in Iran. SCID-5- RV 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.

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

First, *et al.* developed the assessment of 10 Axis II personality disorders in DSM-IV and depressive personality disorder and passive-aggressive personality disorder in the NOS section on Axis II (First *et al.*, 1997). This questionnaire has 119 questions that are administered in less than 20 minutes. 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 (2000) obtained the content validity of the translated version of the test. Ghamkhar Fard, Pourshahbaz, Anderson, and Boland (2021) have validated SCID for DSM-5 based personality disorders in the Iranian population.

4. Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)

This scale is a tool for measuring the severity and type of intellectual and practical obsessions, regardless of their current number and content, developed by Goodman *et al.* (1989). It consists of 10 items; each item is graded on a 5-point Likert scale from zero (asymptomatic) to 4 (very severe), with an overall score in the range between 0 and 40 (Goodman *et al.*, 1989). The reliability between the evaluators for this scale is (r = 0.98) and its internal consistency

coefficient (α = 0.98) (Saboory *et al.*, 1998). Esfahani *et al.* (2012) obtained by 9 the cut-off point of Yale Brown's obsession severity in patients with Iranian obsessive-compulsive disorder.

5. Beck Depression Inventory-II (BDI-II)

It is a self-report questionnaire consisting of 21 items and was developed to assess the severity of depression. In this questionnaire, the items are graded on a 4-point scale (between 0 and 3), with higher scores indicating greater severity of depression. The retest correlation coefficient of the one-week interval and the internal consistency of this questionnaire were equal to 0.93 and 0.92, respectively (Beck *et al.*, 1996). The study of Dobson and Mohammadkhani (2007) showed a total validity coefficient of 0.91 for every 21 items, and the convergent validity of this test was (α = 0.87).

6. Performance Scale of World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)

The Adult Self-Assessment Version of the World Health Organization Disability Table, edition 2, is a 36-item scale that assesses disability in adults 18 years of age and older. This scale has very good reliability and Cronbach's alpha is 0.94 (α = 0.94) (Rajeziesfahani *et al.*, 2019).

7. Kugler and Jones Guilt Inventory (GI)

A test is a self-assessment tool developed by Kugler and Jones between 1988 and 1992. It has 45 items and three subscales. The internal consistency coefficient of this questionnaire for the state of guilt is 0.79, the characteristic of sin is 0.89, and its retest coefficient at two-week intervals, for the scales of "moral criteria", "characteristic of sin", and "state of guilt" are 0.81, 0.72, 56.5 respectively (Kugler & Jones, 1992).

8. Penn Inventory of Scrupulosity (PIOS)

Abramowitz *et al.* (2002) developed the test. It contains 19 self-report items to assess scrupulosity in obsessive content, such as obsessive religious thoughts. Ramezani and Atef Vahid translated and adapted this test and showed that this test has internal stability equal to the alpha of 0.82. The reliability of the test-retest in one month was from 0.72 to 0.85 (Ramezani Farani, 2013).

9. Questionnaire of Religious Beliefs about Washing Rituals

Naziri, Dadfar, and Karimi Keisami (2005) developed the questionnaire of religious beliefs about washing rituals and evaluated patients' attitudes about forced washing rituals, purification, or behavioral abstinence due to their distance from pollution and impurity. Its scoring is based on the Likert system (I strongly agree with a score of 4 to I strongly disagree with a 0). This questionnaire consists of 25 questions, and the scores vary from zero to 100. Cronbach's alpha coefficient for it was calculated to be 0.94.

Quantitative Findings of the Research

This research was a pilot review. In all sessions, we conducted pre-designed content. In the same session or the next session, we asked the client about the process of the session. To correct some parts or keep some items, the client's feedback was very important. After the clients become

familiar with the main concepts of ACT, such as acceptance, cognitive integration, and rupture, as well as mindfulness exercises, the obsessive-compulsive disorder hierarchy was prepared based on the Yale-Brown questionnaire and from low to high intensity with the clients' opinions. Consistent with what we stated in the introduction, the severity of religious obsession of this client was much higher than other obsessive subscales such as checking and contamination. The last exposures of the client were related to this type of obsession. After the exposures, we performed the test; its results are shown in **Table 3**. The severity of clients' obsession has decreased from high to low, and according to the answers to other questionnaires, the improvement process in clients' obsessive-compulsive disorder is evident.

Table 3. The ranking scale at the beginning and after treatment

Ranking scale	Before treatment	After treatment
Yale-Brown Obsessive-Compulsive Scale (Y-BOCS)	25	13
Beck Depression Inventory-II (BDI-II)	14	2
Questionnaire of religious beliefs about washing rituals	51	25
Penn Inventory of Scrupulosity (PIOS)	33	22
Kugler and Jones Guilt Inventory (GI)	146	123
WHODAS 2.0	70	52

RESULTS AND DISCUSSION

Researchers who have treated patients with religious obsessions with a combined therapy model of cognitive-behavioral therapy and exposure and response prevention with religious aspects have reported its effectivity:

Rosli, Sharip, and Wan Ismail (2018) conducted a case study on a person with OCD with religious content. This research introduced an integrated religious treatment along with exposure and response prevention with cognitive reconstruction. With this intervention model, the patient's performance has been improved.

The research conducted by Ansari, Janbozorgi (2016) introduced the cognitive-behavioral therapy model based on religious assumptions as effective in reducing the severity of the obsessive-compulsive disorder.

Some research has evaluated the effectiveness of ACT in patients with obsessive-compulsive disorder and used the 8-session Twohig obsessive-compulsive disorder treatment protocol (Twohig, 2004) and found it to be effective (Rajabi *et al.*, 2019; Philip & Cherian, 2021; Thompson *et al.*, 2021).

Izadi and Abedi (2013) used ACT therapy in a study to reduce the symptoms of obsessive-compulsive disorder in patients with obsessive-compulsive disorder resistant to treatment. This treatment was reported to be effective in 14 sessions.

After reviewing several articles, most studies with the ACT model have been conducted on obsessive-compulsive clients between 8 and 14 sessions. In general, with the studies performed, we can say that, despite the various models, ACT treatment with a religious approach has not been proposed as a single treatment for use for the religious OCD subgroup.

Because scrupulosity is one of the resistant subscales in OCD, we decided to use both integrated therapy and medium-term treatment sessions in the present study. Thus, the religious client can

be accustomed to the treatment model according to its adaptation to verses and narrations and at the same time have more time to gain cognitive flexibility before exposure and no response. The present research is similar to ACT treatment on clients with scrupulosity Lee *et al.* (2018) regarding the number of sessions and their content. The research used 20 sessions of therapy. Our study included religious content in the therapeutic intervention, and the current treatment model allows the therapist to continue the treatment up to 25 weekly sessions. Clinical observations in the initial sessions of our study showed that the client did not have enough insight to discuss its avoidances and behavior change, which is also reported in the study of Lee *et al.* (2018). The interview was completed in the initial sessions, and up to the first 3 sessions as homework, the client was asked to write about the effect of obsession on her life and to read a pamphlet on obsession, described in **Table 2**. This was necessary to gain insight into obsessive-compulsive disorder. From sessions 4 to 10, we explained the ACT components. The client got relative flexibility to conduct exposures and change behavior. Without this time, researchers thought, it would be unlikely that the client could make the behavioral changes required of her by consent because the client was very much in tune with her obsessive thoughts, and it took a long time for the views to flex. ERP in the ACT model was considered only in Lee *et al.* (2018); we considered this aspect in this research. In the present study, we used the OCD hierarchy, but the client was not asked to rate the Subjective Units of Distress (SUDS) at the time of exposure.

CONCLUSION

This research and Lee *et al.* (2018) show that ACT has the potential for good therapeutic success in religious OCD. Although exposure and response prevention is among the primary and common treatments for obsessive-compulsive disorder, as for religious OCD (scrupulosity), in which obsessive thoughts are attached to the beliefs of the client and make difficult to treat, it is necessary first to increase cognitive flexibility and then use the exposure and response prevention. However, more research is needed to discuss the effectiveness of therapies on these patients.

We suggest that this adapted treatment model be performed on a larger number of patients with scrupulosity and with the control group that uses the main ACT protocol to evaluate its effectiveness and generalizability. It should also be compared with studies on other common treatment models.

Limitations

The first limitation was the Coronavirus pandemic; the client could not handle outside exposures due to fewer traffic restrictions. Due to the time limit, we had not a follow-up session.

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CONFLICT OF INTEREST: None

FINANCIAL SUPPORT: None

ETHICS STATEMENT: The Ethical Committee of the University of Social Welfare and Sciences (Ethics Code: IR.USWR.REC.1398.019) has approved the present study.

Before starting the research, we gave the necessary explanations for the clients about the general purpose of the treatment and obtained written informed consent to enter the study. We assured them about the confidentiality of their identifying information.

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