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Original research

Comparing the Effectiveness of Acceptance and Commitment-based Therapy and Intensive Short-term Dynamic Psychotherapy on Ego strength in women with Obsessive Compulsive Disorder

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Abstract

Introduction: My strength, a set of my actions is considered as one of the basic structures of personality. The normal process of transformation requires my ability to face the demands and conflicts of the institution, order, fTherefore, this research aims to compare the effectiveness of treatment based on acceptance and commitment and intensive short-term dynamic psychotherapy. On the strength of me in women suffering from obsessive-compulsive disorder-practice was done.

Research Method: This research was a semi-experimental type with a pre-test, post-test and follow-up plan with a control group. The statistical population of the research included all the patients referred to the consultation centers of Mehr Neuropsychiatric Hospital, Imam Reza and Khorramabad Health Center in the second half of 1401-1402, of which 42 were participants in three short-term dynamic psychotherapy groups (14 people), the treatment based on acceptance and commitment (13 people) and the control group (15 people) were selected by available sampling and placed in the experimental and control groups and according to the psychological strength questionnaire of Clough et al. (2002) in 3 They responded and the treatment group based on acceptance and commitment during 8 sessions based on the treatment protocol according to Hayes et al. and the control group did not receive training, and the obtained data were analyzed by variance analysis with repeated measurements.

Findings: The results showed that the average difference of my strength components in the pre-test-post-test and pre-test-follow-up stages is statistically significant, but the average difference of those scores in the post-test-follow-up stages is not significant.

Conclusion: According to the findings, treatment based on acceptance and commitment has increased the average of those components more compared to short-term dynamic psychotherapy. Based on this, it was concluded that the treatment based on acceptance and commitment is a more effective method to increase my strength in patients with obsessive-compulsive disorder compared to short-term dynamic psychotherapy.

Keywords: ACT, Dynamic Psychotherapy, Ego Strength, Obsessive Compulsive Disorder

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Introduction :

Anxiety and fear are universal human experiences that play a fundamental role in human adaptation and survival. The main function of fear is to make a person aware of a threat or danger. A person may feel anxious before going to an important meeting or a job interview. Another person, after experiencing nausea on the bus, is afraid that this will happen again. Even some specific fears that are well known to clinical professionals, such as fear of heights or fear of closed spaces, are also understandable. But what if the fear is one's own thoughts? And what if these thoughts are about very unlikely and improbable actions or situations? In response to this fear, people learn that apparently certain rituals, or certain ways of responding to which they have become accustomed, lead to temporary relief of their distress, although this response may Logically, it has nothing to do with fear. This unusual and apparently inexplicable anxiety disorder is called obsessive-compulsive disorder (1).

Obsessive-compulsive disorder is a heterogeneous and debilitating disorder that is separate from other anxiety disorders in terms of pathology and treatment, and recently, in the drafts of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, this disorder is called A separate category (separate from depression and anxiety) has been proposed (2). The main symptoms of obsessive-compulsive disorder include recurrent obsessive thoughts or actions that are time-consuming due to their severity or lead to obvious distress or major disturbance (3).

Obsessions are disturbing and recurring thoughts, impulses or images that are experienced unintentionally and inappropriately; While practical obsessions are repetitive behaviors of mental actions that a person feels obliged to perform in response to obsessions or according to rules that are rigidly applied (4). Various factors play a role in the formation and continuation of obsessive-compulsive disorder, and numerous researches have been conducted in this field (5). Also, studies showed that this disorder can affect some components of human physical and psychological health (6).

One of the variables that has a direct relationship to the intensity and weakness of obsessive-compulsive disorder is ego strength (7), which is defined as a part of the basic personality functions that are essential for successful adaptation to the environment (8). The term "man strength" refers to a combination of internal psychological subtleties that a person uses in interacting with others and his social environment (9). These capacities cannot be evaluated independently of the nature of a person's needs and the conditions of his surrounding environment. In relation to my strength, two personality constructs, my restraint and my resilience, have been introduced. These structures are two important aspects of personality functioning and are considered as the central structures of personality in order to understand motivation, emotion and behavior, which are the result of trying to conceptualize "me" (10). In addition, my defensive styles and strategies to cope with stress are also considered as dimensions of my strength along with these two structures (11).

The term self-control refers to how a person is able to control his impulses in a certain situation; Ability to delay gratification, aggressive expression of spontaneity and inhibition of behavior (12). Based on the theory developed by Jack and John Block over the decades, individual differences in self-inhibition dimensions range from over-inhibition to under-inhibition (13). People with overinhibition are relatively inhibited in their actions and their expression of emotions is sometimes too limited. My resilience is derived from the concept of self-control and refers to the dynamic capacity to adjust control in order to optimize the personality system

in relation to the environmental context (14). Therefore, my resilience shows temporary and adaptive changes between different degrees of control. Psychologists have defined resilience as the ability to get rid of negative experiences through flexible adaptation to the changing requirements of stressful experiences (15). People are different in this ability; The greater the resilience of a person, the more he can change the path between degrees of control in an adaptive way. People who are resilient, flexible and able to adapt to new situations more easily; While people with fragile egos can be effective in stable environments, they tend to be persistent and do not manage their stress and anxiety well (16). Researches have shown that obsessive thinking is caused by the failure to control thoughts in the first place, and it also leads to an extreme effort in suppressing thoughts, which results in the intensification and strengthening of these thoughts. As a result, the effort to control and control increases and the cycle of extreme effort continues. Overinhibition and weakness in resilience have been shown in many researches as characteristics of people suffering from obsessive-compulsive disorder (17).

Nygren (18) believes that people who have high ego strength show high resilience in the face of various challenges, but people who have weak ego strength show weakness in enduring anxiety and distress. . A high ego strength helps a person to maintain his stability and emotional stability in stressful situations, while a weak ego strength causes a greater perception of threats and emotional turmoil. Therefore, it seems that the formation of mental disorders is related to the level of my strength (19). The research findings of Mesina et al. (20) showed that patients with high I strength are treated and recovered faster, but the treatment of patients with low I strength is slower. Therefore, referring to the importance of ego strength and its influential role on individual and interpersonal psychological dynamics and activities, and helping to discover the influencing mechanisms of this structure.

Several treatments have been suggested for the treatment of obsessive-compulsive disorder. Among these treatments, the method that has received more attention in recent years is the treatment based on acceptance and commitment. Acceptance and Commitment Therapy, which was proposed in the 80s by Hayes (21) at the University of Nevada and known as ACT (22). Acceptance and Commitment Therapy (ACT) unlike the traditional cognitive behavioral therapy approach, does not work directly on reducing symptoms, but instead targets the utility and function of psychological experiences such as thoughts, feelings, memories, and psychological sensations. to give This method tracks meaningful life activities regardless of their existence (23). Its underlying principles include: 1- Acceptance (tendency to experience pain or other disturbing events without trying to control them); 2- Value-based action (commitment combined with desire to act, as meaningful personal goals rather than eliminating unwanted experiences).

Also, there are linguistic methods and cognitive processes that lead to healthy functioning in interaction with other non-verbal dependencies. This method includes exercises based on exposure, linguistic metaphors and methods such as mental care. In this treatment, instead of changing cognitions, an attempt is made to increase a person's psychological connection with his thoughts and feelings. In this treatment, it is first tried to increase the psychological acceptance of the individual about mental experiences (thoughts, feelings) and in turn reduce the ineffective control actions (24). The patient is taught that any action to avoid or control these unwanted mental experiences is ineffective or has the opposite effect and causes them to

intensify and should (these experiences without any internal or external reaction to remove them) Fully accepted (25). The central process of treatment based on acceptance and commitment teaches people how to stop inhibiting thoughts, how not to get mixed up with disturbing thoughts, and makes a person tolerate unpleasant emotions more (26). Treatment based on acceptance and commitment can have a positive effect on many symptoms and clinical manifestations of obsessive-compulsive disorder, such as avoidance, inhibition of thought, impaired quality of life, and mood problems (27).

Among other treatments proposed in this study is short-term intensive dynamic psychotherapy. The most basic focus of this treatment is on emotional or psychological pain, in which life is imagined as a difficult and exhausting process, the psyche is built in the conflict to cope and endure it, and defenses or avoidance mechanisms are created. It causes pain; Ways of seeing, thinking, feeling and behaving that most of these activities happen outside of consciousness (28). These unconscious attempts to avoid emotional pain often fail, but because our awareness is limited, they are nevertheless repeated over and over again. The healing process involves re-formulating the experience and tolerating the resulting discomfort. The understanding that therapists and clients create about these problems expands the client's awareness and opens the way to new options for conflict management. It also increases the client's capacity to bear emotional pain and deal with dissatisfaction and increases his ability to think and be curious about his experiences (29).

Short-term dynamic psychotherapy evolved through the activities of Malan and colleagues, and the common features of intensive short-term psychodynamic intervention are the experience of deep emotions during the treatment session, high levels of therapist activity, encouraging the patient to cooperate and active attention to Time limit, as well as having therapeutic focus and selection criteria are special (30). Lipro and Maltepi (31) emphasized that one of the emphasis of short-term dynamic therapies is the continuous effort of the therapist for deep emotional/emotional experience as a healing element. Extensive studies in the last two decades have shown that disclosure, whether in speech or writing, improves physical and mental health, as well as the functioning of the immune system and autonomic nerves (32). The active position of the therapist and the correct application of techniques make the patient obtain the optimal result in the shortest possible time (33). Emphasis of short-term dynamic psychotherapy is on immediate help to the patient to experience unconscious emotions that have caused unconscious anxiety, symptoms of disorder and various defenses. Short-term psychodynamic psychotherapy has been clinically effective in samples with multiple psychiatric problems and samples of patients with high resistance depression and personality disorders (34).

According to the mentioned materials, it can be said that although the components of the research have been investigated in several studies, the combination of variables in the current research has not been used in any independent study so far. Also, no study has investigated the effectiveness of the above two treatment methods on obsessive-compulsive disorder. Therefore, the general purpose of the above study is the treatment based on acceptance and commitment and intensive short-term dynamic psychotherapy on my strength in women with OCD. Obsessive-compulsive disorder should be compared.

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Research Method:

This research was a semi-experimental type with a pre-test, post-test and follow-up plan with a control group. The statistical population of the research included all the patients who referred to the consultation centers of Mehr Neurological and Psychiatric Hospital, Imam Reza and Khorram Abad Health Center in the second half of 1401-1402, of which 42 participants, taking into account the entry criteria (getting a score of 20) and above that in the obsessive-practical questionnaire; not taking drugs for obsessive-compulsive disorder; the same length of time suffering from obsessive-compulsive disorder; not suffering from other psychological and personality disorders) and criteria for exiting the research (use of psychiatric and psychoactive drugs; Absence of more than 2 sessions in therapy sessions; simultaneous participation in other courses and therapeutic interventions at the same time as research) in three groups of short-term dynamic psychotherapy (14 people), treatment based on acceptance and commitment (13 people) and control group (15 people) were selected by available sampling and placed in experimental and control groups and answered the mental strength questionnaire of Clough et al. Treatment according to the method of Hayes and his colleagues (1999) and the short-term dynamic psychotherapy group based on the Dovanlo treatment protocol (2000) was planned during 8 sessions of 90 minutes and the control group did not receive training and the data obtained by analysis of variance with measurement was repeatedly analyzed.

The research tool was the scale of my strength: psychological strength questionnaire was created in 2002 by Clough et al. This scale has 48 questions and 6 subscales (challenge, commitment, emotional control, life control, self-confidence in abilities and personal self-confidence) in a 5-point Likert scale ranging from 1 (completely disagree) to 5. (Strongly agree) was assessed. The test-retest reliability coefficient was reported by Kalf et al. (35), 0.9, and in these studies, Cronbach's alpha coefficients were reported as 0.93. In this research, the reliability of the subscales was determined by Cronbach's alpha method and the following values were obtained for each of the subscales: emotion control: 0.77, life control: 0.78, challenge: 0.78, commitment: 0.74., confidence (abilities): 0.78, and confidence (interpersonal): 0.75, while the reliability of overall psychological strength was also 0.93 (35). The correlation coefficients calculated by Besharat (36) to assess the validity of internal consistency in the subscales of challenge, commitment, emotion control, life control, confidence in abilities and interpersonal confidence are 0.71, 0.70, 0.73 respectively. 0, 0.72, 0.80 and 0.74 were reported. This scale has been used in various researches in the country. In the present study, the reliability of this structure using Cronbach's alpha for the subscales of challenge, commitment, emotional control, life control, self-confidence in abilities and individual self-confidence was 0.88, 0.87, and 80. 0, 0.73, 0.79 and 0.81 were obtained, which indicates the appropriate reliability of the questionnaire.

Acceptance and Commitment Therapy: In the current study, a treatment protocol was developed based on the method of Hayes and his colleagues in 1999. This program was implemented by the therapist in 8 weeks, 1 session of 90 minutes per week for patients suffering from obsessive-compulsive disorder.

Table 1. Description of the acceptance and commitment treatment package

Meeting	Target	The content of the meetings
First	Interview and assessment, explanation of conditions and treatment process, explanation of the underlying model of ACT	Training and implementation of mindfulness exercises that must be implemented in each session, change through the use of mood frustration exercise, hard cover exercise to explain the treatment process.
Second	Explaining the concept of acceptance and living in the now	Mindfulness practice, in this session we talk about satisfaction, primary and secondary suffering, using the metaphor of a wanderer, using the metaphor of walking in the rain.
Third	Explanation of the concept of contextual self	Practicing mindfulness, considering oneself as a context, allegorizing smooth sands, axing at the root of reasoning, using the incongruous technique.
Fourth	Explaining the concept of breaking from language threats	Practicing mindfulness, putting yourself in context, practicing facing the giant iron man, doing the "yes, but" method.
fifth	Initial assessment of values and explanation of goals	Mindfulness practice, thought suppression practice
sixth	Clarification of values	Mindfulness practice, bus values compass, goal setting, activity planning
seventh	Explanation of the concept of committed action	Mindfulness practice, observer practice, chess board analogy
Eighth	Ending meetings and conclusions with the aim of preparing for relapse to preventing relapse	Practice the content on the flashcards, let's live life's lifelong assignments.

Intensive short-term dynamic psychotherapy: In the present study, the treatment model based on Dovanlo's treatment protocol (1995, 2000) was carried out in 8 sessions of 90 minutes on patients with obsessive-compulsive disorder. The purpose and content of the sessions have been compiled according to the short-term psychodynamic psychotherapy manual, that is, the seven stages of questioning about problems, pressure, challenge, transference resistance, direct access to the unconscious, transference analysis and dynamic exploration in the unconscious.

Table 2: Description of the intensive short-term dynamic psychotherapy package in 8 sessions

Meeting	Target	The content of the meetings
First	Referral, asking about the patient's problem	Scanning sequence starts with asking about the patient's problem. Here, the patient's ability to respond and explore the nature and factors of his problem is determined
Second	Pressure technique	Usually, the patient expresses his problems and symptoms in a vague and unclear manner. At this stage, the patient resists the therapist's pressure for more specific and accurate answers and recognition of the true nature of the

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		emotions experienced, such as anger, and the therapist relieves the pressure by requesting a detailed and complete understanding of the patient's inner experience of his feelings. increases
Third	Challenge with resistance	Following the therapist's pressure, between the patient's resistance (desire to escape from pain) and the therapeutic agreement (desire to get rid of the problem), an intrapsychic conflict is created and tactical and basic defenses are activated. At this stage, the therapist explains their nature and consequences to the patient and challenges them by confronting and blocking them.
Fourth	Manifestation of transitional resistance and challenge with it	Challenging with resistance leads to the arousal of complex transitional emotions. At this stage, the therapist tries to break the transference-related defense systems by using clarification and challenge. In this process, the internal tension between the resistance and the therapeutic contract reaches its maximum and this process continues until the therapeutic contract overcomes the resistance and the possibility of breaking into the unconscious pathological material of the patient is provided.
fifth	Reaching the unconscious by overcoming the therapeutic contract over resistance	At this stage, the patient really touches his transferred feelings. Using the imagination to depict the impulse is the method that is used at this stage for the patient to access the full experience and express emotions. As a result, both the therapist and the patient can observe the pathological forces directly.
sixth	Transfer analysis	At this stage, the therapist analyzes the transition by using the conflict triangle and the person triangle. The therapist also analyzes the similarities and differences of the patient's method in defending painful and anxiety-provoking feelings in his current, past and transitional relationships, so that the patient can understand the style of his defenses against the feelings and problems he creates for himself. He has to gain insight so that he can give up his defenses.
seventh	Dynamic research in the unconscious	At this stage, due to the complete mastery of the therapeutic contract, repeated breakthroughs occur in the unconscious emotions, and the unconscious emotions of anger, guilt, sadness, and love are revealed and experienced. At this stage, the therapist analyzes and summarizes the process of the dynamic sequence and reinforces the insight that the patient has gained.
Eighth	Summary and completion	Final summary, re-implementation of questionnaires, appreciation and thanks and ending the treatment

Findings:

In this research, there were 42 participants in three groups: short-term dynamic psychotherapy (14 people), acceptance and commitment therapy (13 people) and control group (15 people). The mean and standard deviation of the age of the participants in the short-term dynamic psychotherapy group were 31.79 and 3.91 years, respectively, in the acceptance and commitment-based therapy group, 29.31 and 5.44 years, respectively, and in the group The control was equal to 32.27 and 5.22 years. There were 4 men and 10 women in the dynamic psychotherapy group, 3 men and 10 women in the acceptance and commitment therapy group, and 4 men and 11 women in the control group. In the dynamic psychotherapy group, 2 participants had an undergraduate degree, 7 had a diploma, 1 had a bachelor's degree, and 3 had more than a bachelor's degree. In the treatment group based on acceptance and commitment, the level of education of 3 participants was under diploma, 5 had a diploma, 2 had a bachelor's degree, and 3 had more than a bachelor's degree. In the control group, the level of education of 3 of the participants was under diploma, 8 had a diploma, 1 had a bachelor's degree, and 3 had more than a bachelor's degree. In the dynamic psychotherapy group, 6 people were single and 8 people were married, in the acceptance and commitment therapy group, 4 people were single, 7 people were married, and 2 people were separated from their spouses, and in the control group, 5 people were single, 9 people were married, and 1 person was separated from his wife. Table 3 shows the average, standard deviation and Shapiro-Wilk index (significance level) of each of the components of my strength in the participants of the research groups, in the three stages of pre-test, post-test and follow-up.

Table 3: Mean, standard deviation and Shapiro-Wilk values (significance level) of each component

Variable	component	group	pre-test	post-test	follow-up
M ± SD	Challenge	ACT	3.80 ± 17.61	4.21 ± 26.46	4.26 ± 26.79
		Dynamic psychotherapy	3.75 ± 16.43	3.87 ± 24.71	3.78 ± 23.50
		control group	2.26 ± 16.60	2.76 ± 17.80	2.63 ± 17.27
	obligation	ACT	4.16 ± 22.15	6.36 ± 36.15	6.51 ± 34.15
		Dynamic psychotherapy	22.86 ± 5.20	4.87 ± 31.28	5.96 ± 29.14
		control group	5.28 ± 24.40	6.87 ± 25.13	5.19 ± 23.73
	Emotional control	ACT	3.60 ± 17.46	3.49 ± 24.69	3.68 ± 23.92
		Dynamic psychotherapy	3.40 ± 16.21	4.73 ± 22.93	4.42 ± 24.50
		control group	3.77 ± 18.33	4.36 ± 18.07	3.51 ± 17.20
	Life control	ACT	4.42 ± 15.76	4.17 ± 23.45	3.84 ± 25.53

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		Dynamic psychotherapy	3.21 ± 16.00	20.79 ± 4.10	3.56 ± 21.92
		control group	3.02 ± 17.53	3.25 ± 17.00	3.70 ± 16.33
	Trust in your abilities	ACT	5.66 ± 19.69	32.84 ± 5.03	4.68 ± 31.69
		Dynamic psychotherapy	5.91 ± 20.50	29.86 ± 4.11	28.21 ± 4.09
		control group	4.16 ± 21.80	22.93 ± 4.14	3.78 ± 20.47
	Interpersonal trust	ACT	3.54 ± 14.92	3.58 ± 23.00	3.42 ± 23.77
		Dynamic psychotherapy	3.31 ± 15.71	22.36 ± 3.30	22.14 ± 4.00
		control group	3.07 ± 17.00	3.43 ± 18.07	3.29 ± 17.13
Shapiro-Wilk (Sig)	Challenge	ACT	0.930 (0.344)	0.943 (0.502)	0.974 (0.937)
		Dynamic psychotherapy	0.861 (0.032)	0.926 (0.265)	0.954 (0.624)
		control group	0.956 (0.621)	0.929 (0.271)	0.944 (0.436)
	obligation	ACT	0.962 (0.781)	0.949 (0.586)	0.947 (0.558)
		Dynamic psychotherapy	0.928 (0.288)	0.957 (0.668)	0.912 (0.169)
		control group	0.942 (0.406)	0.940 (0.379)	0.905 (0.114)
	Emotional control	ACT	0.913 (0.201)	0.921 (0.260)	0.944 (0.507)
		Dynamic psychotherapy	0.931 (0.316)	0.917 (0.196)	0.890 (0.082)
		control group	0.930 (0.276)	0.909 (0.130)	0.943 (0.415)
	Life control	ACT	0.916 (0.221)	0.914 (0.207)	0.941 (0.468)
		Dynamic psychotherapy	0.943 (0.458)	0.947 (0.520)	0.982 (0.985)
		control group	0.941 (0.394)	0.952 (0.551)	0.913 (0.148)
	Trust in your abilities	ACT	0.965 (0.826)	0.932 (0.362)	0.864 (0.043)

	Dynamic psychotherapy	0.985 (0.995)	0.968 (0.845)	0.942 (0.449)
	control group	0.885 (0.056)	0.950 (0.518)	0.887 (0.061)
Interpersonal trust	ACT	0.900 (0.133)	0.973 (0.923)	0.948 (0.570)
	Dynamic psychotherapy	0.958 (0.685)	0.899 (0.109)	0.938 (0.393)
	control group	0.892 (0.072)	0.911 (0.142)	0.940 (0.387)

Table 3 shows that in the two test groups, the average scores of the six components of my strength have increased in the post-test and follow-up phases. On the other hand, no similar changes were observed in the mentioned stages in the control group. Table 1 shows that the Shapiro-Wilk value related to the challenge component (p=0.032) in the dynamic psychotherapy group in the pre-test stage and confidence in one's abilities (p=0.043) in the acceptance and commitment-based therapy group It is significant in the follow-up phase. Although this article shows the non-normal distribution of those two components in the mentioned group and stage, despite this, considering the significance level obtained for the Shapiro-Wilk index, the close sample size in the groups and the resistance of the statistical tests of analysis of variance against Deviation from the assumptions can be expected that this amount of deviation from the assumption does not invalidate the results of the analysis.

In this research, Lon's test was used to evaluate the homogeneity of error variances of the dependent variables and the results showed that the difference in the error variance of the scores related to any of the components in the groups and in the three stages is not significant. This finding shows that the assumption of homogeneity of error variances among the data related to the research variables was maintained. Next, the assumptions of homogeneity of the covariance matrices of the dependent variables were examined using the M. Box statistic and the sphericity condition or the assumption of the equality of the covariance matrix of the errors using the Moheli test, the results of which are presented in Table 4.

Table 4: The results of the hypothesis test of the equality of the variance-covariance matrices and the equality of the error covariance matrix

Variable	Equality of variance matrix of covariances			Equality of the error covariance matrix		
	M.Box	F	P	Procrastination index	$\chi^{۲}$	p
Challenge	15.77	1.16	0.230	0.988	0.48	0.788
obligation	13.06	0.97	0.480	0.939	2.41	0.300
Emotional control	13.67	1.01	0.436	0.931	2.70	0.259
Life control	16.41	1.21	0.267	0.951	1.89	0.388
Trust in your abilities	14.14	1.05	0.404	0.923	3.05	0218
Interpersonal trust	10.23	0.76	0.697	0.843	6.57	0.037

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The results of the analysis in Table No. 4 show that the M. Box statistic index is not significant for any of the components of my strength. This article shows the establishment of the assumption of homogeneity of the covariance matrices of the dependent variables among the data. Also, Table 4 shows that the chi-square value obtained from Moheli's test is significant for the interpersonal trust component (p=0.037). This finding indicates that the assumption of sphericity was not established for that component, and for this reason, the degrees of freedom related to those scores were modified using the Geisser-Greenhaus method.

After evaluating the assumptions of the analysis and ensuring that they are established, the data were analyzed using the variance analysis method with repeated measurements. Table 5 shows the results of multivariate analysis comparing the effect of implementation of acceptance and commitment-based therapy and short-term dynamic psychotherapy on the components of my strength.

Table 5: The results of multivariate analysis in evaluating the effect of independent variables on mine strength

The dependent variable	Wilks Lambda	F	df	P	$^{۲}\eta$	Power of a test
Challenge	0.582	5.26	4 , 76	0.001	0.237	0.979
obligation	0.596	5.61	4 , 76	0.001	0.228	0.972
Emotional control	0.469	8.74	4 , 76	0.001	0.315	0.999
Life control	0.532	7.06	4 , 76	0.001	0.271	0.993
Trust in your abilities	0.566	6.26	4 , 76	0.001	0.248	0.985
Interpersonal trust	0.537	6.93	4 , 76	0.001	0.267	0.992

According to the results of table number 5, the effect of implementing independent variables on challenge components (Wilks' lambda = 0.582, $^{2}\eta$ = 0.237, P = 0.001, F = 5.26), commitment (Wilks' lambda = 0.596 , $^{2}\eta$= 0.228, P = 0.001, F = 5.61), emotional control (Wilks lambda = 0.469, 2η = 0.315, P = 0.001, F = 8.74) life control (Wilks lambda = 0.523, $^{2}\eta$ = 0.271, P = 0.001, F = 7.06), confidence in one's abilities (Wilks lambda = 0.566, 0.248 = 2 2η, P = 0.001, F = 6.26) and interpersonal trust (Wilks lambda = 0.537, 2η = 0.267, P = 0.001, F = 6.93) is significant. Table No. 6 shows the results of variance analysis with repeated measurements comparing the effect of acceptance and commitment-based therapy and dynamic psychotherapy on the components of my strength.

Discussion and conclusion:

This research was conducted with the aim of comparing the effectiveness of acceptance and commitment-based therapy and short-term intensive dynamic psychotherapy on my strength in women with obsessive-compulsive disorder and the results showed the difference in the average of my strength components in the pre-test, post-test and pre-test stages. The follow-up test is statistically significant, but the average difference of those scores in the stages of the follow-up post-test is not significant. Also, the difference in the average strength components in the two experimental groups is significant compared to the control group. So that both

methods of treatment based on acceptance and commitment and short-term dynamic psychotherapy led to an increase in the average scores of the components of my strength, and the changes caused by both methods of treatment remained intact after two months of the intervention.

In addition, the difference in the effect of two treatments based on acceptance and commitment and dynamic psychotherapy on the components of challenge (p=0.040), commitment (p=0.042) and life control (p=0.046) is significant. Is. So that the treatment based on acceptance and commitment has increased the average of those components more compared to short-term dynamic psychotherapy. Therefore, it was concluded that the treatment based on acceptance and commitment is a more effective method to increase my strength in patients with obsessive-compulsive disorder compared to short-term dynamic psychotherapy.

The results are in line with the research findings of Akbarian et al. (11), Enayat et al. (17), Moqtader and Pak-saresht (9), Barzegar et al. (2017), Jensen et al. 16) is aligned.

In explaining the effectiveness of treatment based on acceptance and commitment on obsessive compulsive patients, it can be said that in this treatment approach, it is believed that pain is an inevitable part of life that can be accepted, while trying To avoid pain causes more suffering. Fighting pain is considered as a form of non-acceptance or resistance to "what is". The intensity of suffering depends on the degree of integration of clients with thoughts and emotions related to pain (19). Related studies show that avoidance is a common response to chronic pain and can take many forms, such as avoiding work or social activities or overusing alcohol, food, or medication. This method often helps in the short term, but in the long term, experiential avoidance leads to frustration, dissatisfaction with life, and feelings of insignificance (14).

In fact, acceptance techniques in acceptance and commitment therapy (such as observing and accepting thoughts and emotions as they are) help to tolerate pain. Pain acceptance seems to represent an adaptive form of coping with pain, whereby a person responds to pain-related experiences without trying to control them, and engages in worthwhile activities as well as achieving personal goals, regardless of these negative experiences. be (11). Therefore, the use of pain acceptance techniques is considered a positive way to regulate pain, which leads to lower levels of pain intensity and disability.

Another process of psychological flexibility is committed action. Commitment to doing what needs to be done is a key component in acceptance and commitment therapy (16). In this approach, the therapist emphasizes moving toward a vital life rather than fighting pain. This process is defined as the ability to function effectively in accordance with personal values in the presence of negative private experiences (19). In the client's act, he learns to pursue valuable activities such as social contact, sports, intimate relationships, parental roles, professional work or social participation that give meaning to life, regardless of pain (Yu 11). Therefore, acceptance and commitment therapy does not rely on pain control, but rather helps clients to better accept pain and the limitations associated with it, act based on their values, and apply the principles they have learned during therapy in their daily lives. merge Therefore, although the purpose of the act is not to reduce pain, it leads to pain reduction; Because patients accept more pain and focus more on important aspects of their lives.

The results of the statistical analysis showed that intensive short-term dynamic psychotherapy is also effective on women with obsessive-compulsive disorder. In explaining this finding, it can be said that short-term dynamic psychotherapy has invented a reliable method for compassionately dealing with resistance, strengthening the will and motivation of patients to

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face the past and liberate the true self. What Dovanlo saw, and ISTDP therapists continue to see, is that humans have an innate power, will, and drive to heal that is more powerful than even the most debilitating mental health problems. ISTDP is, at its core, a method designed to unleash the healing power that can emerge within each of us and bring it to full potential in healing. What is so beautiful and inspiring about the ISTDP is working with people who, often for decades, are suddenly finding the strength and confidence to change their lives (32). Unconscious processes can lead to negative health effects in any body system. including digestive system, cardiovascular system, respiratory system, immune system, muscular system and skin. Anxiety and defensiveness can lead to increased concern about the body and negative interactions with the treatment and health system. In addition, these problems can secondarily lead to disability and depression. ISTDP therapists understand that the patient's problems are caused by defenses that develop in response to anxiety associated with unconscious emotion. Anxiety and defenses may be completely unconscious to the person experiencing them. As a result of those destructive relationships, physical symptoms and a wide range of psychiatric symptoms. Majority of patients suffering from anxiety, depression, substance abuse and interpersonal problems have emotional blocking (34).

One of the reasons for the acceptance of this treatment method is that at first it is done to familiarize the patient with these unconscious processes and then to help the patient to overcome emotional blocking processes, and this often means simultaneously focusing on the emotions that the patient has in the treatment room during the interview. and points to the ways in which the patient avoids feelings and communication with the therapist. When these feelings are experienced, tension, anxiety, and other physical and defensive symptoms quickly subside. Then the patient and the therapist can see the emotional drivers that were being defended against. Afterwards, a healing process may occur in which old avoided feelings are experienced and resolved. This therapy is not a “one size fits all” therapy: it is tailored to each individual and their anxiety tolerance. has been If the patient has a very low tolerance for anxiety, treatment first helps to develop anxiety tolerance and the ability to reflect on the body's symptoms and thoughts. When anxiety tolerance is improved, the patient begins to experience emotions safely. At the end of a successful treatment, physical anxiety and core defenses disappear. Therefore, the patient's health and relationships are free to develop as they were before the original trauma. This therapy and its variants have been extensively researched. It has been shown to be effective for depression, anxiety, somatic symptoms, substance abuse, eating disorders, and obsessive-compulsive disorder (34).

This research, like other researches, has limitations, among them, the number of samples, people with obsessive-compulsive disorder referred to the hospital, and therefore it is not possible to generalize the results to other patients with semi-clinical obsessive-compulsive disorders: limitation in the selection of the group Considering some psychological variables (such as clients' knowledge and attitude about therapeutic interventions, their psychological expectations and mindset) and demographic variables (such as education level and economic conditions), the sample is considered as another limitation of the current research, so it is suggested that Obsessed people in the society such as the elderly, physically ill, students, and students should also be done and in addition, the effect of follow-up should be investigated in the long term.

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