Journal of
Research in Psychopathology
https://doi.org/10.22098/jrp.2026.19686.1369

2026; Vol. 7, No. 3
Pages: 54 - 64

Original Article

Efficacy of the integrated protocol of ACT for OCD and couples in improving psychological flexibility and marital satisfaction of couples with relationship obsessive compulsive disorder (ROCD): A pilot study

Soheila Qomian [1*], Mohammad Reza Shaeiri [2] & Hojjatollah Farahani [3]

1. Assistant Professor, Department of Psychology, Faculty of Humanities and Social Sciences, University of Mazandaran, Babolsar, Mazandaran, Iran.
2. Associate Professor, Department of Psychology, Faculty of Humanities, Shahed University, Tehran, Iran.
3. Associate Professor, Department of Psychology, Faculty of Humanities, Tarbiat Modares University, Tehran, Iran.

Abstract

The aim of the present study was to evaluate the efficacy of the integrated protocol of Acceptance and Commitment Therapy (ACT) for OCD and couples on improving psychological flexibility and marital satisfaction of patients with Relationship Obsessive-Compulsive Disorder (ROCD). The present study was conducted as a single-subject study with a multiple baseline design. The sample consisted of married students (patients) studying in Tehran universities who had an ROCD diagnosis. In the integrated treatment of ACT for OCD and couples, 2 patients; in ACT for OCD, 2 patients; and in ACT for couples, 2 patients were randomly assigned by lottery and then studied. Baseline scores on the Acceptance and Action Questionnaire-II (AAQ-II) ranged from 17 to 27, increasing after treatment to 35-56 (MBLR: 50-100%; RCI: 4.37-8.74; PND = 100% for all six participants). On the ENRICH Marital Satisfaction Scale, baseline scores ranged from 25 to 48, increasing after treatment to 23-69 (MBLR: 36-100%; RCI: 3.10-6.56; PND = 100% for participants 1, 2, and 4, and 66.66% for participant 5). All participants showed clinically significant change. The integrated ACT for OCD and couples protocol was the most effective. In this pilot study, the integrated protocol of ACT for OCD and couples was the most effective in increasing psychological flexibility and marital satisfaction of clients compared to the other two treatments.

Keywords

Acceptance and Commitment Therapy (ACT)
Couples
New ROCI
New PROCSI
Relationship Obsessive-Compulsive Disorder (ROCD)

Received: 2026/05/03
Accepted: 2026/06/11
Available Online: 2026/08/30

Introduction

Results of past research has shown that patients with OCD often have communication difficulties compared to the general population. For example, a decreased probability of marriage and an increased likelihood of distress in marital life are among their problems (Kliem et al., 2025; Fineberg et al., 2025; Abramowitz et al., 2025). However, most of these studies are cross-sectional and do not establish causality; it remains unclear whether OCD symptoms lead to marital distress or vice versa.

Doron et al. (2012) have suggested that when the focus of OCD symptoms is on the relationship, it has a more devastating effect on the couple's intimate communication. In this regard, they have introduced a new theme of OCD called Relationship Obsessive-Compulsive Disorder (ROCD). This disorder focuses on obsessions related to intimate communications and involves doubts about the relationship with the spouse or their characteristics, as well as excessive checking behaviors, comparison of the spouse with others, and so on. ROCD symptoms, similar to other OCD symptoms, can cause negative reactions from the spouse and be a source of communication conflicts. This situation may be more prominent in ROCD because the focus of one's doubts and preoccupations is on the intimate relationship with one's spouse. Constant conflicts with a spouse can have devastating effects on marital satisfaction and affect the survival of the relationship (Knopp et al., 2025).

The relationship between ROCD symptoms and marital dissatisfaction has been investigated in two studies using a nonclinical population (Doron et al., 2012a; Doron et al., 2012b). In fact, it can be said that OC symptoms focused on relationship and focused on spouse, each, in a rather different way, has a unique role in marital dissatisfaction (Doron et al., 2012b). However, it is worth noting that the relationship between ROCD and marital dissatisfaction is a two-way relationship. Thus, just as doubts focused on spouse and relationship decrease marital satisfaction,

Corresponding author: Assistant Professor, Department of Psychology, Faculty of Humanities and Social Sciences, University of Mazandaran, Babolsar, Mazandaran, Iran. E-mail: **s.qomian@umz.ac.ir**

decreased marital satisfaction (which may be caused by other factors) may play a great role in increasing doubts focused on spouse and relationship (Doron et al., 2014). A critical limitation of these foundational studies is that they were conducted on nonclinical student samples, limiting the generalizability of the findings to clinical populations with ROCD.

Patients with ROCD, like other patients with OCD, only seek treatment when they experience significant distress. The diagnosis of ROCD becomes more complex when it is believed that such experiences constitute a natural part of the relationship being formed and reflect the natural problems of life, even if distressing. In addition, patients with ROCD usually seek treatment when they experience relationship instability (such as increased pressure from the spouse, low marital satisfaction) (Doron et al., 2014).

Many studies have suggested the benefits of cognitive behavioral interventions for OCD. However, many people still suffer from residual symptoms, despite an adequate number of treatment sessions, and some may have limited access to treatment sessions. For this reason, specialists and researchers are looking for ways to improve the conceptual and practical aspects of existing therapeutic approaches. One of these ways is to use acceptance-based approaches (Abramowitz et al., 2018). Acceptance-based interventions lead to the reduction of problems such as subjective decline, which are commonly observed in traditional methods such as exposure in CBT (Eifert & Heffner, 2003; Levitt et al., 2004).

Acceptance and Commitment Therapy (ACT) (Hayes et al., 2011) is one of the acceptance-based treatments for OCD whose purpose is to foster psychological flexibility-being in the present moment without conflict with private experiences such as thoughts and emotions, and a tendency to accept unwanted internal events (like obsessive thoughts and anxiety)- (Abramowitz et al., 2018; Twohig et al., 2015). ACT emphasizes the development of psychological flexibility (Doorley & Kashdan, 2025), which has been supported in various studies (Doorley & Kashdan, 2025., Stockton et al., 2025). Various studies have shown that a decrease in psychological flexibility is associated with OCD symptoms (Twohig et al., 2025) and the growth and persistence of anxiety and mood disorders (Spinhoven et al., 2014).

In fact, increasing psychological flexibility is the process of change the ACT. According to the Hexaflex model, psychological flexibility is defined as "the ability to be in contact with the present moment more fully as a conscious human being, and to change or persist in behavior when doing so serves valued ends" (Hayes et al., 2006). This multidimensional capacity consists of six interrelated core processes: acceptance, cognitive defusion, contact with the present moment, self-as-context, values, and committed action (Hayes et al., 2006; Rad et al., 2025). Twohig et al. (2015), in a randomized controlled trial, examined the change in psychological flexibility of 41 patients with OCD in the ACT sessions process and compared these changes with changes in 38 OCD patients who received advanced relaxation training. Multiple levels of analysis showed that changes in psychological flexibility at posttest mediated the change in severity of OCD symptoms from the pre-test to the follow-up period.

On the other hand, as noted, OCD, especially with relationship theme has adverse effects on the communication context of couples as well as marital satisfaction and over time, the relationship between these two aspects of marital dissatisfaction and OCD can be observed. Thus, due to the bilateral relationship between OCD symptoms and interpersonal function, it seems that by incorporating the spouse of the person with OCD into the treatment process and by paying attention to the persistent communication factors of OCD, the effects of treatment will increase (Abramowitz et al., 2013). In this regard, Belus et al. (2014) showed that couple-based cognitive-behavioral therapy for OCD significantly improved patient-spouse communication performance, couple communication, and short-term crises, and the improvement in communication skills continued over time. In addition, the results of the study by Mehta (Renshaw & Caska-Wallace, 2025) showed that assistance from a spouse (or a family member) during Exposure and Response Prevention (ERP) would increase the efficacy of this intervention. However, these couple-based studies suffer from small sample sizes and lack long-term follow-up assessments. Moreover, most of these interventions were based on CBT/ERP, not ACT, leaving a significant gap in the literature regarding acceptance-based couple interventions for OCD.

Several studies have examined ACT for couples dealing with general relationship problems, not specifically OCD. Peterson et al. (2009) found that ACT was effective in increasing marital satisfaction and adjustment in distressed couples, while Zarling and Berta (2017) showed that ACT reduced aggression in couples. In Iran, too, several studies have tested ACT for couples and found it helpful for issues such as relationship distress, intimacy, and forgiveness (Amanollahi et al., 2014; Zanganeh Motlagh et al., 2017; Rajabi et al., 2013; Akhavan Bitaghsir et al., 2017; Honarparvaran, 2014). At the same time, ACT for OCD has mostly been used with individuals alone, without involving couple-related issues (Twohig et al., 2015; Twohig et al., 2025). nevertheless, no study so far has tested an integrated ACT protocol that targets both OCD symptoms and couple issues together in ROCD. Nevertheless, a methodological critique of these Iranian studies is warranted: most lack a control group, rely on small convenience samples, and do not report effect sizes or clinically significant change indices. These limitations reduce the internal validity of the evidence supporting ACT for couples in Iran.

Thus, on the one hand, given the poor prognosis of patients with ROCD, if not treated (such as become chronic the disorder and comorbidity with depression and anxiety disorders), on the other hand, with regard to the increased likelihood of interpersonal conflicts among patients with ROCD, spouse adjustment or vice versa, negative reactions of the spouse, and ultimately exacerbation of ROCD symptoms, there is a clear need for specific interventions to improve ROCD. In this regard, it seems on the one hand, considering the efficacy of ACT in improving the

psychological flexibility - as one of the most important processes of ACT - of patients with OCD and to compensate for some gaps of CBT (such as dropout rates, residual symptoms, and treatment non-acceptability), on the other hand, considering the efficacy of ACT on enhancing marital adjustment and satisfaction, the research question is: Is the integrated protocol of ACT for OCD and couples more effective than ACT for OCD alone and ACT for couples alone in improving psychological flexibility and marital satisfaction of patients with ROCD?

Method

Participants

The present study was conducted as a single-subject study with a multiple baseline design to evaluate the efficacy of the integrated protocol of ACT for OCD and couples on improving psychological flexibility and marital satisfaction in Iranian couples. The statistical population of the current study included all married students (patients) from various colleges and majors at Tehran universities, including University of Tehran, Shahid Beheshti, Tarbiat Modares, Shahed, Kharazmi, Amirkabir, Sharif University of Technology, and Khajeh Nasir, between 2020 and 2022, who had an ROCD diagnosis. In the current study, participants who were selected from patients with OCD with relationship theme (ROCD) and referred to in a previous study (Ghomian et al., 2021a), were randomly assigned to the experimental groups by lottery. Due to the challenges of sampling patients with ROCD and using a single-subject study with a multiple baseline design, in the integrated treatment of ACT for OCD and couples, 2 patients; in ACT for OCD, 2 patients; and in ACT for couples, 2 patients were studied. Inclusion criteria in the current study were: being married (male or female), diagnosis of OCD according to SCID-5-RV, diagnosis of ROCD (scores above two standard deviations from the mean on the new ROCI and PROCSI scales) (Melli et al., 2018), being married for at least six months, consent to participate in the study and signed written informed consent. Exclusion criteria in the current study were: they have been in psychotherapy or hospitalization in psychiatric hospitals for the past 6 months, history of substance abuse (due to interference with treatment sessions), and suffering other mental disorders except other obsessive spectrum disorders, according to the Structured Clinical Interview based on DSM-5-Research Version (SCID-5-RV).

Instrument

Acceptance and Action Questionnaire II (AAQ-II) (Bond et al., 2011):

This questionnaire is a 10-item version of the original questionnaire (AAQ-I) developed by Hayes (Hayes et al., 2004). The AAQ-II measures a construct that relates to diversity, acceptance, experiential avoidance, and psychological inflexibility. The psychometric properties of the original version are as follows: the results from 2816 participants across six samples indicated that the instrument had satisfactory construct validity and reliability. The mean alpha coefficient was 0.84 (0.78 to 0.88) and test-retest coefficients over 3 to 12 months were 0.81 and 0.79, respectively. The AAQ-II appears to measure a concept similar to the AAQ-I, but has better psychometric stability (Bond et al., 2011).

ENRICH Marital Satisfaction Questionnaire (Fowers & Olson, 1993):

This questionnaire is used to assess potentially problematic areas or identify strong and productive areas in marital relationships. This questionnaire is used to identify couples who have marital dissatisfaction and need counseling, education, and relationship strengthening. Due to the length of the original form of the questionnaire (115 questions), several shorter forms have been developed. First, Olson (1998) introduced a 15-question form and later developed a 47-question form. The alpha coefficients of the subscales of the ENRICH marital satisfaction questionnaire in the report by Olson et al. (1982) ranged of 0.48 to 0.90. Olson and Olson (2000) reported the reliability of the 47-question form using Cronbach's alpha coefficient, which was 0.92.

New Partner-Related Obsessive-Compulsive Symptoms Inventory (New PROCSI) (in accordance with Iranian culture) (Ghomian et al., 2022):

This Iranian-culture-based scale consists of 22 items loading onto a single factor. This scale consists of one factor. After content analysis, the factor consisted of a combination of compulsions and obsessive thoughts related to spouse characteristics (such as intelligence, competence, sociability, morality, emotional stability, physical appearance). In confirmatory factor analysis, this scale showed significant superiority in terms of the chi-square index compared to the original PROCSI. Also, in the previous study (Ghomian et al., 2021), the new PROCSI showed better convergent validity with Depression, Anxiety and Stress Scale (DASS), Relationship beliefs inventory (RBI), Obsessive-Compulsive Inventory-Revised (OCI-R) and especially Obsessive Beliefs Questionnaire (OBQ) than the original PROCSI and also better divergent validity with Dyadic Adjustment Scale (DAS) than the original PROCSI. The test-retest correlation coefficient of this scale over two weeks was 0.86 which was significant at $P < 0.01$. Additionally, its Cronbach's alpha was 0.91.

New Relationship Obsessive-Compulsive Inventory (New ROCI) (in accordance with Iranian culture) (Ghomian et al., 2022):

This Iranian-culture-based scale consists of 19 items and two factors. After content analysis, factor 1 refers to obsessive thoughts about loving a spouse, being loved by a spouse and the “correctness” of the relationship, and factor 2 refers to compulsive behaviors about loving a spouse, being loved by a spouse and “correctness” of the

relationship. In confirmatory factor analysis, the new ROCI showed significant superiority in terms of all fitness indicators over the original ROCI. Also, in the previous study (Ghomian et al., 2021), this scale showed better convergent validity with Depression, Anxiety and Stress Scale (DASS), Relationship beliefs inventory (RBI), Obsessive-Compulsive Inventory-Revised (OCI-R) and especially Obsessive Beliefs Questionnaire (OBQ) than the original ROCI and also better divergent validity with Dyadic Adjustment Scale (DAS) than the original ROCI. The correlation coefficients of test-retest of this scale within two weeks, for factor 1, factor 2, and the total score were 0.85, 0.78, and 0.79, respectively, all of which were significant at P <0.01. Also, Cronbach's alpha for factor 1, 2 and total score was 0.60, 0.74 and 0.83, respectively.

ACT protocol for OCD (Twohig, 2004):

This protocol contains 10 sessions of ACT for OCD. A summary of this protocol is presented in Table 1.

ACT protocol for couples (Peterson et al., 2009; Lev & McKay, 2017):

This protocol consists of 10 sessions. A summary of this protocol is presented in Table 2.

Integrated protocol of ACT for OCD and couples (Peterson et al., 2009; Twohig, 2004; Lev & McKay, 2017):

In the integrated sessions of ACT for OCD and couples, the content of couple ACT sessions and individual ACT for OCD sessions go hand in hand. This integrated protocol includes separate individual ACT sessions for OCD (10 sessions) and couple ACT sessions (10 sessions), delivered concurrently. A summary of this protocol is presented in Table 3.

Table 1. ACT Protocol for OCD (Twohig, 2004)

Session	Content
1–2	Gathering information about obsessive thoughts and behaviors; explaining the difference between obsessive thoughts and behaviors
3–5	Showing how trying to control obsessive thoughts is the problem, not the solution
6–8	Changing the psychological function of obsessive thoughts from threatening to merely another verbal event
9–10	Discussing the client's values and increasing behavioral commitments to pursue those values

Table 2. ACT Protocol for Couples (Peterson et al., 2009; Lev & McKay, 2017)

Session	Content
1	Getting to know the couples and presenting an orientation to ACT
2	Individual assessment
3	Constructive frustration; reviewing options and what is controllable vs. uncontrollable
4	Mindfulness and acceptance training
5	Cognitive defusion; reviewing barriers to thoughts, tagging thoughts, and moving away from them
6	Observing thoughts
7	Choosing valuable orientations
8	Exploring obstacles to a valuable life
9	Describing self as a context in communication
10	Commitment action, end of treatment, and relapse prevention

Table 3. Integrated Protocol of ACT for OCD and Couples (Peterson et al., 2009; Twohig, 2004; Lev & McKay, 2017)

Phase	Session	Focus	Content
1	1–2	Initial evaluation	Understanding ACT logic and rationale for integrated treatment; individual and couple assessment
2	3–4	Constructive hopelessness	Reviewing what has been tried before and why it didn't work (both individually and as a couple)
3	5–8	Acceptance & mindfulness	Learning to accept unwanted thoughts (OCD) and relationship difficulties (couple) without fighting them
4	9–14	Cognitive defusion & self-as-context	Seeing thoughts as just words; separating self from obsessive content and relationship doubts
5	15–20	Values & committed action	Identifying shared couple values and committing to value-driven behaviors despite unwanted thoughts

Procedure

According to the single-subject study with a multiple baseline design, data analysis included visual analysis of graphs, trend and stability indices, the Percentage of Non-overlapping Data (PND), Percentage of Overlapping Data (POD), Reliable Change Index (RCI), and Mean BaseLine Reduction(MBLR) were used.

This study used a multiple baseline design across participants, meaning each participant served as their own control. The number of assessments was three baseline sessions, ten treatment sessions (one assessment per session), and two follow-up sessions (one at two weeks and one at four weeks after treatment). Visual analysis of the baseline data showed stable trends for all participants before treatment began, which supports the validity of the comparisons. All baseline, treatment, and follow-up assessments were conducted by the same researcher to maintain consistency. None of the patients were taking any medication. Patients who missed three treatment sessions in a row were removed from the study. This study was approved by the Ethics Committee under code IR.SHAHED.REC.1397.078.

Results

After conducting a clinical interview in a previous study (Ghomian et al., 2021) and selecting participants who achieved high scores (above two standard deviations from the mean on the new ROCI and PROCSI scales) (Melli et al., 2018), in order to more accurately measure OCD, SCID-5-RV and the new version of the ROCI and PROCSI were administered on them and finally, with the loss of the 2 patients who had been included from the beginning of the study, 6 patients agreed to participate in this study. Coincidentally, Two of them were assigned to ACT for OCD, two, along with their spouses, were assigned to ACT for couples, and the remaining two, along with their spouses, were assigned to the integrated treatment. All participants were randomly assigned to the treatment conditions. For each of the participants, 3 baseline sessions were scheduled and conducted in the weeks before treatment. In addition, 3 evaluation sessions (during and immediately after treatment) and 2 follow-up sessions (each conducted within two weeks) were included. Participants 1 and 2 were treated with integrated treatment of ACT for OCD and couples, participants 3 and 4 were treated with ACT for OCD, and participants 5 and 6 were treated with ACT for couples. It is important to note that due to the limited data of the follow-up stage (two data sets), its data were used solely to assess the percentage of change in participants. Inter-situational and cross-situational visual analysis (including stability envelope, relative level, and absolute level) was not performed due to the limited data.

None of the participants gave consent to provide a broader report of their personal stories. Therefore, we present only a brief description of their demographic and clinical features below.

- Demographic and clinical characteristics of the participants

The participants were six married women, with an average age of about 31 years. All were master's or PhD students at universities in Tehran. The duration of marriage ranged from 1 to 15 years, and the duration of ROCD symptoms ranged from 1 to 5 years. The main symptoms of ROCD included doubts about infidelity, doubts about love and being loved, and doubts about illness. Participants 1 and 2 received the integrated treatment. Participants 3 and 4 received ACT for OCD. Participants 5 and 6 received ACT for couples.

- Visual analysis of participants in the AAQ-II

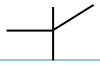
As shown in Table 4, all participants in the baseline stage showed stable changes with respect to the stability envelope. Also, with the exception of participants 1 and 4, who did not show 100% stability within the stability envelope during the treatment phase (stability rate: 66.66%), the remaining participants showed stable changes within the stability envelope. Moreover, the change in relative and absolute level for all participants in the treatment phase (comparing the two halves of treatment) was positive and accordingly, the trend of participants`s changes was rising. Thus, the scores of all participants on the AAQ-II have changed.

Table 4. Inter-situational visual analysis for participants in the AAQ-II

Position sequence	**Base line stage**						**Treatment stage**					
Participants	1	2	3	4	5	6	1	2	3	4	5	6
Number of meetings	3	3	3	3	3	3	20	20	10	10	10	10
Level												
Middle	24	22	27	21	17	24	42	44	41	36	30	38
Average	23.66	21.66	26	22.66	18	23.33	43.66	43	40.33	35.33	29.66	35.33
Variation range	23-24	18-25	24-27	20-27	17-20	21-25	33-56	35-50	35-45	29-41	24-35	28-40
Stability envelope	19.2-28.8	17.6-26.4	21.6-32.4	16.8-25.2	13.6-20.4	19.2-20.4	33.6-50.4	35.2-52.8	32.8-49.2	28.8-43.2	24-36	30.4-45.6
Percentage of stability envelope data	100	100	100	100	100	100	66.66	100	100	100	100	66.66
Range of stability envelope changes	Stable	Stable	Stable	Stable	Stable	Stable	Variable	Stable	Stable	Stable	Stable	Variable
Level change												
Relative level change	+0.5	-1.5	0	+3.5	-1.5	-0.5	+11.5	+7.5	+5	+6	+5.5	+6
Absolute level change	+1	-3	0	+7	-3	-1	+23	+15	+10	+12	+11	+12
Trend												
Direction	Ascending	Descending	at the same level	Ascending	Descending	Descending	Ascending	Ascending	Ascending	Ascending	Ascending	Ascending
Stability	Stable	Stable	Stable	Stable	Stable	Stable	Variable	Stable	Stable	Stable	Stable	Stable
Percentage of stability envelope data	100	100	100	100	100	100	66.66	100	100	100	100	100

As shown in Table 5, the overall trend of participants' scores from baseline to treatment stage was positive, which indicates an increase in their scores on the AAQ-II from baseline to treatment stage. Also, the PND and POD of all participants were 100 and 0, respectively, which indicates the efficacy of all treatments in increasing the AAQ-II scores of the participants. In addition, as shown in Diagram 1, all participants improved.

Table 5. Cross-situational visual analysis for participants in the AAQ-II

Compare the position	**Base line and treatment stage**					
Participants	**1**	**2**	**3**	**4**	**5**	**6**
Trend changes						
Direction change						
The type of trend	Positive	Positive	Positive	Positive	Positive	Positive
Stability change	Stable to variable	Stable to stable	Stable to stable	Stable to stable	Stable to stable	Stable to variable
Level change						
Relative level change	24 to 37.5	20 to 39.5	25.5 to 38	24 to 32.5	17 to 27	22.5 to 33
Absolute level change	24 to 33	22 to 35	27 to 35	27 to 29	17 to 24	24 to 28
Middle change	24 to 42	22 to 44	27 to 41	21 to 36	17 to 30	24 to 38
Average change	23.66 to 43.66	21.66 to 43	26 to 40.33	22.66 to 35.33	18 to 29.66	23.33 to 35.33
Data overlap						
PND	100	100	100	100	100	100
POD	0	0	0	0	0	0

All participants showed a clinically significant change on the AAQ-II during the treatment and follow-up phases compared to baseline. The overall mean MBLR (Mean Baseline Reduction) scores for participants 1 through 6 were 91%, 99%, 55%, 70%, 57.5%, and 61%, respectively. Among these, participants 1 and 2 (who received the integrated treatment) had the highest MBLR and RCI (Reliable Change Index) scores. This indicates that the integrated treatment was the most effective in increasing psychological flexibility compared to the other two treatments. As shown in Diagram 1, all participants showed a significant increase on the AAQ-II.

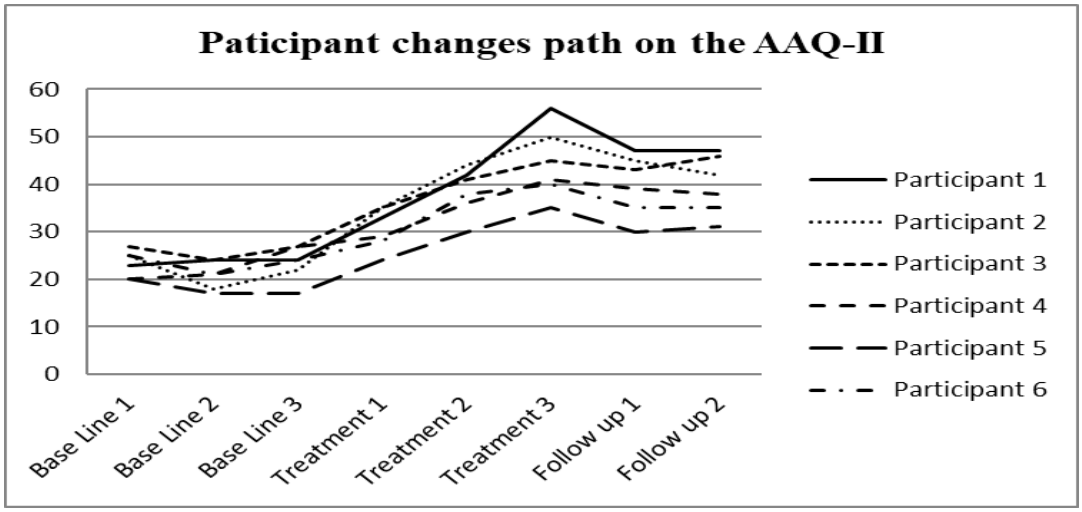


Figure 1. Participant changes path on the AAQ-II

- Visual analysis of participants in the ENRICH marital satisfaction scale

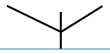
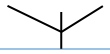
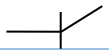
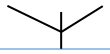
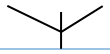
As shown in Table 6, all participants in the baseline stage showed a stable change with respect to the stability envelope. Also, the sixth participant in the treatment phase showed stable changes with respect to the stability envelope. Participants 1, 3, and 4 also showed relatively stable changes in the treatment phase (66.66% stability). Moreover, the relative and absolute level of all participants in the treatment phase (comparing the two halves of treatment) was positive, and accordingly, the trend of participants`s changes was increasing. As such, the scores of participants in ENRICH marital satisfaction scale have changed.

Table 6. Inter-situational visual analysis for participants in the ENRICH marital satisfaction scale

Position sequence	**Base line stage**						**Treatment stage**					
Participants	1	2	3	4	5	6	1	2	3	4	5	6
Number of meetings	3	3	3	3	3	3	20	20	10	10	10	10
Level												
Middle	38	31	40	42	25	46	52	52	50	52	36	55
Average	36.33	31	40.66	41.33	25	45.33	55	53	51.66	53	34.33	55.33
Variation range	33-38	29-33	40-42	40-42	25-25	42-48	44-69	40-67	40-65	44-63	23-44	48-63
Stability envelope	30.4-45.6	24.8-37.2	32-48	33.6-50.4	20-30	36.8-55.2	41.6-62.4	41.6-62.4	40-60	41.6-62.4	28.8-43.2	44-66
Percentage of stability envelope data	100	100	100	100	100	100	66.66	33.33	66.66	66.66	33.33	100
Range of stability envelope changes	Stable	Stable	Stable	Stable	Stable	Stable	Variable	Variable	Variable	Variable	Variable	Stable
Level change												
Relative level change	-2.5	-1	0	-1	0	-1	+12.5	+13.5	+12.5	+9.5	+10.5	+7.5
Absolute level change	-5	-2	0	-2	0	-2	+25	+27	+25	+19	+21	+15
Trend												
Direction	Descending	Descending	at the same level	Descending	at the same level	Descending	Ascending	Ascending	Ascending	Ascending	Ascending	Ascending
Stability	Stable	Stable	Stable	Stable	Stable	Stable	Variable	Variable	Variable	Stable	Variable	Stable
Percentage of stability envelope data	100	100	100	100	100	100	66.66	66.66	66.66	100	33.33	100

As shown in Table 7, the scores of the PND and POD of participants 1, 2 and, 4 were 100 and 0, respectively, which indicates the high efficacy of integrated treatment of ACT for OCD and couples as well as ACT for OCD for these participants in terms of changing the scores of the ENRICH marital satisfaction scale. However, the PND and POD of participants 5 were 66.66 and 33.33, respectively, which indicates relative efficacy of ACT for couples in relative decline of the ENRICH marital satisfaction scale of the participant. Also, as shown in Diagram 2, all clients have changed.

Table 7. Cross-situational visual analysis for participants in the ENRICH marital satisfaction scale

Compare the position	**Base line and treatment stage**					
Participants	**1**	**2**	**3**	**4**	**5**	**6**
Trend changes						
Direction change						
The type of trend	Positive	Positive	Positive	Positive	Positive	Positive
Stability change	Stable to variable	Stable to variable	Stable to variable	Stable to variable	Stable to variable	Stable to stable
Level change						
Relative level change	35.5 to 48	30 to 46	41 to 45	41 to 48	25 to 29.5	44 to 51.5
Absolute level change	33 to 44	31 to 40	40 to 40	40 to 44	23 to 25	46 to 48
Middle change	38 to 52	31 to 52	40 to 50	42 to 52	25 to 36	46 to 55
Average change	38 to 52	31 to 53	40.66 to 51.66	41.33 to 53	25 to 34.33	45.33 to 55.33
Data overlap						
PND	100	100	66.66	100	66.66	66.66
POD	0	0	33.33	0	33.33	33.33

All participants showed a clinically significant change on the ENRICH scale during the treatment and follow-up phases compared to baseline. The overall mean MBLR scores for participants 1 through 6 were 60.5%, 93.5%, 27.5%, 50.5%, 29.5%, and 54%, respectively. Participants 1 and 2 (who received the integrated treatment) had the highest MBLR and RCI scores. This shows that the integrated treatment was the most effective in increasing marital satisfaction. Although participant 6 had lower scores than the others, the improvement was still clinically meaningful. As shown in Diagram 2, all participants, especially the first and second participants receiving the ntegrated treatment of ACT for OCD, showed the highest increase on the ENRICH marital satisfaction scale.

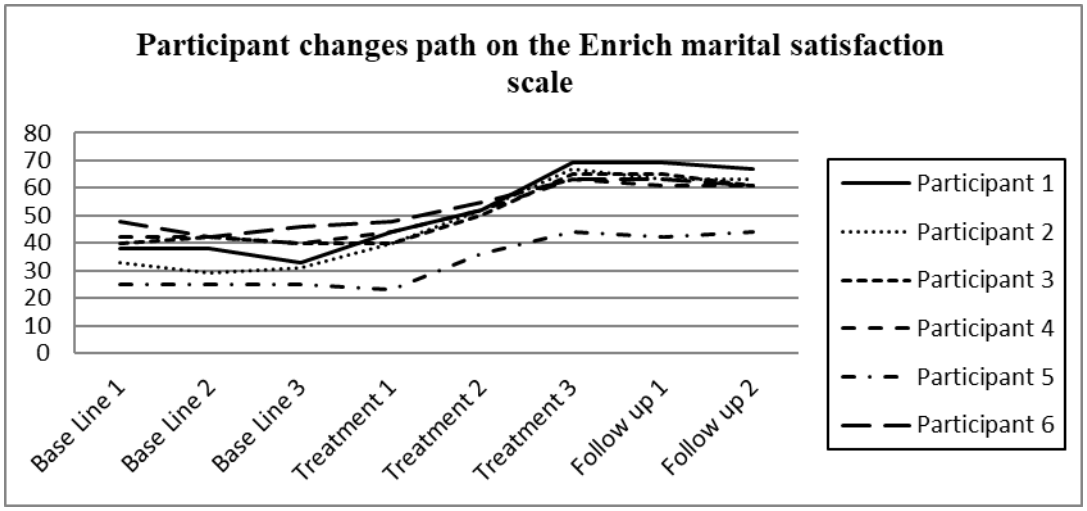


Figure 2. Participant changes path on the ENRICH marital satisfaction scale

Discussion

The results of the current study showed that participants who received the integrated treatment of ACT for OCD and couples demonstrated the highest rate of recovery and the greatest effect size compared to other clients in terms of increased psychological flexibility and marital satisfaction.

In the treatment of ACT for OCD, the range of individual reactions to obsessions and anxiety is reduced. As such, one's performance improves and this improvement is not directly related to the levels of obsessions or anxiety (Twohig et al., 2014; Teymoori et al., 2022). Thus, it could be expected that ACT in this study would also show its efficacy in the functional context of OCD and increase clients' psychological flexibility and, subsequently, their marital satisfaction, while reducing experiential avoidance. The expectation was achieved in the current study.

Another finding of the present study was an increase in psychological flexibility among participants. Indeed, the findings suggest a link between improved psychological flexibility and decreased severity of OCD (Twohig et al., 2025; Haaland et al., 2017). Also, the results of research has shown that impairment in psychological flexibility is associated with symptoms of OCD (Twohig et al., 2025) and the persistence of mood and anxiety disorders (Twohig et al., 2015; Spinhoven et al., 2014). Thus, an increase in psychological flexibility is expected in clients treated with ACT.

It is noteworthy that all clients across all forms of ACT showed significant changes in the level of psychological flexibility in the treatment and follow-up stages. Indeed, given that increasing psychological flexibility is the process of change in ACT (Twohig et al., 2015), it can be expected that all forms of ACT will lead to increased psychological flexibility.

Another result of the current study was the increased marital satisfaction of all participants in the treatment and follow-up stages. As shown in the current study, many clients had either been betrayed by their spouses or had betrayed their spouses . Further examination of their histories revealed that clients or their spouses had a history of non-traditional relationships with the opposite sex before marriage. The results of various studies have shown that this type of relationship history has an impact on marital satisfaction in Iranian culture. For example, the results by Nejad Karim et al. (2016) showed that there is a significant relationship between a history of premarital relationships and emotional, physical and sexual infidelity. In other cultures, most studies have also reported a negative relationship between premarital relationships with marital quality and marital satisfaction (Strauss, 2012; Legkauskas & Stankevičienė, 2009). According to the study by Treas and Giesen (2000), couples who have an informal cohabitation before marriage, even if they adhere to their sexual and religious values, still have a 39% higher chance of marital infidelity.

The notable point in the current study is that the history of the premarital relationship had an impact on marital satisfaction through the uncertainty it created in the person about their spouse's infidelity. As a result, following increased psychological flexibility and reduced obsessive symptoms, couples' marital satisfaction is expected to increase, which is what happened in the current study. However, it is also worth noting that in addition to clients who received ACT for OCD alone or the integrated protocol, clients who received ACT for couple alone also showed increased marital satisfaction. In fact, given that ACT for couples targets relationship problems between couples and the thoughts that contribute to the formation of

these problems, it can be expected that ACT for couples will lead to improved marital satisfaction. These findings are consistent with those of Peterson et al. (2009), Zarling et al. (2017), Carson et al. (2004), and Christensen et al. (2004). Overall, consistent with the current research, the impact of couple therapy of ACT on improving marital satisfaction has been shown in numerous studies (Burpee & Langer, 2005; Pruitt & McCollum, 2010; Kavousian et al., 2015; Jafari, 2015; Jafari & Dehghani, 2017).

Indeed, in explaining the impact of ACT on marital satisfaction, it can be said that from an ACT perspective, the formation and persistence of distress and conflict in couples are the result of experiential avoidance strategies and maladaptive control strategies that are conceptualized in couples' communication context. ACT stops this process and thereby reduces couple suffering that results from avoidance efforts (Peterson et al., 2009).

Symptoms of ROCD, similar to symptoms of other OCD subtypes, may lead to negative reactions from the spouse and be considered a source of communication conflicts (Doron et al., 2014). Thus, it can be expected that couples' satisfaction will also increase with the improvement of symptoms of OCD. In this regard, the results of the study by Kliem et al. (2025) showed that behavioral therapies aimed at improving OCD will result in improved marital adjustment.

As observed in the client change process, the initial steps of the various ACT protocols focused on helping clients accept unpleasant experiences as they are, instead of avoiding unpleasant experiences (experiential avoidance). In fact, acceptance helps couples move beyond ineffective discussions to unlock radical change and and provides a space for couples to accept their thoughts and feelings without trying to change them, to think without judgment, and to reduce their conflicts (Peterson & Eifert, 2011). In the mid- to late stages of the ACT protocols, we observed increased present-moment awareness and greater attention to values and commitment to them. Burpee and Langer (2005) argued that mindful individuals may feel less threatened by change. In a state of mindfulness, beliefs and attitudes about a spouse and relationship are more flexible and changeable. Thus, in the present study, as mindfulness increased, couples' conflicts decreased, which was followed by increased marital satisfaction. The impact of mindfulness on marital satisfaction has been shown in numerous studies (Carson et al., 2004; Burpee & Langer, 2005). Also, in the final steps of ACT, we saw increased attention to values and commitment to them in clients. In general, it can be concluded that clarifying values and committing to them provides an opportunity for couples to behave in ways that enhance satisfaction, which in turn improves communication quality and reduces psychological and interpersonal suffering (Peterson et al., 2009; Flaxman et al., 2011).

clarifying values and committing to them provides an opportunity for couples to behave in ways that enhance satisfaction, which in turn improves communication quality and reduces psychological and interpersonal suffering. Also, the unequal number of sessions in the integrated protocol (20 sessions) compared to the other two protocols (10 sessions each), the lack of a placebo control group to increase internal validity, the fact that multiple evaluations (baseline, treatment, and follow-up) were conducted by the researcher, and that all three treatments were delivered by the researcher due to limited access to other therapists, and time constraints are other limitations of the current study.

Conclusion

The integrated protocol of ACT for OCD and couples was the most effective in increasing psychological flexibility and marital satisfaction of clients compared to ACT for OCD alone and ACT for couple alone.

Acknowledgment

We would like to thank all the participants and specialists who collaborated with us in conducting this research. We would also like to thank Shahed University for its financial support in conducting this research.

Disclosure Statement

The authors declare that there is no conflict of interest regarding the publication of this article.

ORCID

Soheila Qomian: https://orcid.org/0000-0001-5498-4808

References

Abramowitz, J. S., Baucom, D. H., & Twohig, M. P. (2025). Couple-based interventions for OCD: A new generation of treatments. *Behavior Therapy*, 56(2), 301-318.

Abramowitz, J. S., Baucom, D. H., Wheaton, M. G., Boeding, S., Fabricant, L. E., Paprocki, C., & Fischer, M. S. (2013). Enhancing exposure and response prevention for OCD: A couple-based approach. *Behavior Modification*, 37(2), 189–210. doi:10.1177/0145445512444596

Abramowitz, J. S., Blakey, S. M., Reuman, L., & Buchholz, J. L. (2018). New directions in the cognitive-behavioral treatment of OCD: Theory, research, and practice. *Behavior Therapy*, 49(3), 311-322. doi:10.1016/j.beth.2017.09.002

Akhavan Bitaghsir, Z., Sanaei Zaker, B., Navabiinejad, S., & Farzad, V. (2017). A comparison of the effectiveness of emotion-based couple therapy and acceptance and commitment therapy on couples' satisfaction and marital adjustment. *Journal of Health Education and Health Promotion*, 5(2), 121-128 [Persian]. doi:10.30699/acadpub.ijhehp.5.2.121

Amanollahi, A., Heidarianfar, N., Khojasteh Mehr, R., & Imani, M. (2014). Effectiveness of acceptance and commitment therapy (ACT) in the recovery of couples distress. *Journal of Applied Counseling*, 4(1), 105-120 [Persian]. doi:10.22055/jac.2015.12561

Belus, J. M., Baucom, D. H., & Abramowitz, J. S. (2014). The effect of a couple-based treatment for OCD on intimate partners. *Journal of Behavior Therapy and*

Experimental Psychiatry, 45(4), 484-488. doi:10.1016/j.jbtep.2014.07.001

Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., Waltz, T., & Zettle, R. D. (2011). Preliminary psychometric properties of the Acceptance and Action Questionnaire-II: A revised measure of psychological flexibility and experiential avoidance. *Behavior Therapy*, 42(4), 676-688. doi:10.1016/j.beth.2011.03.007

Burpee, L. C., & Langer, E. J. (2005). Mindfulness and marital satisfaction. *Journal of Adult Development*, 12(1), 243-267. doi:10.1007/s10804-005-1281-6

Carson, J. W., Carson, K. M., Gil, K. M., & Baucom, D. H. (2004). Mindfulness-based relationship enhancement. *Behavior Therapy*, 35(3), 471-494. doi:10.1016/S0005-7894(04)80028-5

Christensen, A., Atkins, D. C., Berns, S., Wheeler, J., Baucom, D. H., & Simpson, L. E. (2004). Traditional versus integrative behavioral couple therapy for significantly and chronically distressed married couples. *Journal of Consulting and Clinical Psychology*, 72(2), 176-191. doi:10.1037/0022-006X.72.2.176

Doorley, J. D., & Kashdan, T. B. (2025). Acceptance and commitment therapy: New directions and a systematic review of psychological flexibility. *Clinical Psychology Review*, 105, 102420.

Doron, G., Derby, D. S., & Szepsenwol, O. (2014). Relationship obsessive compulsive disorder (ROCD): A conceptual framework. *Journal of Obsessive-Compulsive and Related Disorders*, 3(2), 169–180. doi:10.1016/j.jocrd.2013.12.005

Doron, G., Derby, D., Szepsenwol, O., & Talmor, D. (2012a). Tainted love: Exploring relationship-centered obsessive compulsive symptoms in two non-clinical cohorts. *Journal of Obsessive–Compulsive and Related Disorders*, 1(1), 16–24. doi:10.1016/j.jocrd.2011.11.002

Doron, G., Derby, D., Szepsenwol, O., & Talmor, D. (2012b). Flaws and all: Exploring partner-focused obsessive–compulsive symptoms. *Journal of Obsessive–Compulsive and Related Disorders*, 1(3), 234–243. doi:10.1016/j.jocrd.2012.05.004

Doron, G., Szepsenwol, O., Derby, D., & Nahaloni, E. (2012). Relationship-related obsessive–compulsive phenomena: The case of relationship-centered and partner-focused obsessive compulsive symptoms. *Psicoterapia Cognitiva e Comportamentale*, 18(1), 71-82.

Eifert, G. H., & Heffner, M. (2003). The effects of acceptance versus control contexts on avoidance of panic-related symptoms. *Journal of Behavior Therapy and Experimental Psychiatry*, 34(3-4), 293–312. doi:10.1016/j.jbtep.2003.11.001

Fineberg, N. A., Van Ameringen, M., & Drummond, L. (2025). The global epidemiology of obsessive-compulsive and related disorders in the 21st century: An updated systematic review. *World Psychiatry*, 24(1), 45-62.

Flaxman, P. E., Blackledge, J. T., & Bond, F. W. (2011). *Acceptance and commitment therapy: Distinctive features*. Routledge/Taylor & Francis Group.

Fowers, B. G., & Olson, D. H. (1993). ENRICH marital satisfaction scale: A brief research and clinical tool. *Journal of Family Psychology*, 7(2), 176–185. doi:10.1037/0893-3200.7.2.176

Ghomian, S., Shaeiri, M. R., & Farahani, H. (2021). Designing the Relationship Obsessive-Compulsive Inventory (ROCI) based on Iranian culture and evaluation of its psychometric properties. *Iranian Journal of Psychiatry*, 16(4), 418–429. doi:10.18502/ijps.v16i4.7229

Ghomian, S., Shaeiri, M. R., & Farahani, H. (2021). Relationship Obsessive Compulsive Disorder (ROCD) in Iranian culture: Symptoms, causes and consequences. *Journal of Fundamentals of Mental Health*, 23(6), 397–408. doi:10.22038/jfmh.2021.19322

Ghomian, S., Shaeiri, M. R., & Farahani, H. (2022). Designing, factor structure, validity, and reliability of the New Partner-Related Obsessive-Compulsive Symptoms Inventory (New PROCSI): A questionnaire based on Iranian culture. *Journal of Fundamentals of Mental Health*, 24(6), 391–401. doi:10.22038/jfmh.2022.21465

Haaland, A. T., Eskeland, S. O., Moen, E. M., Vogel, P. A., Haseth, S., Mellingen, K., & Hummelen, B. (2017). ACT-enhanced behavior therapy in group format for trichotillomania: An effectiveness study. *Journal of Obsessive-Compulsive and Related Disorders*, 12, 109–116. doi:10.1016/j.jocrd.2017.01.005

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy*, 44(1), 1–25. doi:10.1016/j.brat.2005.06.006

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2011). *Acceptance and commitment therapy: The process and practice of mindful change (2nd ed.)*. Guilford Press.

Hayes, S. C., Strosahl, K. D., Wilson, K. G., Bissett, R. T., Pistorello, J., Toarmino, D., Polusny, M. A., Dykstra, T. A., Batten, S. V., Bergan, J., Stewart, S. H., Zvolensky, M. J., Eifert, G. H., Bond, F. W., Forsyth, J. P., Karekla, M., & McCurry, S. M. (2004). Measuring experiential avoidance: A preliminary test of a working model. *The Psychological Record*, 54, 553–578. doi:10.1007/BF03395492

Honarparvaran, N. (2014). The effectiveness of acceptance and commitment therapy (ACT) on forgiveness and marital adjustment of women affected by spouse infidelity. *Women and Society* (Women's Sociology), 5(3), 135-150 [Persian].

Jafari, E. (2015). Efficacy of acceptance and commitment therapy on decreasing depression, marital satisfaction and resiliency of wives of veterans in Najaf Abad city [Unpublished master's thesis]. *Islamic Azad University* [Persian].

Jafari, E., & Dehghani, A. (2017). The effectiveness of acceptance and commitment therapy on resilience and marital satisfaction of male veterans' wives. *Modern Psychological Research*, 13(51), 83-63 [Persian]. doi:20.1001.1.27173852.1397.13.51.4.6

Kavousian, J., Harifi, H., & Karimi, K. (2015). The effectiveness of acceptance and commitment therapy (ACT) on couples' marital satisfaction. *Health & Care*, 18(4), 76-87 [Persian].

Kliem, S., Klan, Y., & Biel, A. (2025). Marital adjustment and obsessive-compulsive disorder: A 35-year follow-up and meta-analysis. *Journal of Obsessive-Compulsive and Related Disorders*, 44, 100891.

Knopp, K., Rhoades, G. K., & Stanley, S. M. (2025). Divorce, relationship dissolution, and obsessive-compulsive symptoms: A longitudinal cohort study. *Journal of Family Psychology*, 39(1), 88-102.

Legkauskas, V., & Stankevičienė, D. (2009). Premarital sex and marital satisfaction of middle aged men and women: A study of married Lithuanian couples. *Sex Roles*, 60(1-2), 21-32. doi:10.1007/s11199-008-9497-0

Lev, A., & McKay, M. (2017). *Acceptance and commitment therapy for couples*. Context Press.

Levitt, J. T., Brown, T. A., Orsillo, S. M., & Barlow, D. H. (2004). The effects of acceptance versus suppression of emotion on subjective and psychophysiological response to carbon dioxide challenge in patients with panic disorder. *Behavior Therapy*, 35(4), 747–766. doi:10.1016/S0005-7894(04)80018-2

Melli, G., Carraresi, C., Pinto, A., Caccico, L., & Micheli, E. (2018). Valutare il disturbo ossessivocompulsivo da relazione: proprietà psicometriche della versione italiana di ROCI e PROCSI. *Psicoterapia Cognitiva e Comportamentale*, 24(3).

Nejad Karim, E., Saeedifar, T., Wahidnia, N., & Ahmadi, K. (2016). The role of premarital relationships in emotional problems after marriage. *Social Health*, 3(4), 299-226 [Persian]. doi:10.22037/ch.v3i4.13176

Olson, D. H. (1998). *PREPARE/ENRICH counselor's manual: Version 2000*. Life Innovations, Inc.

Olson, D. H., & Olson, A. K. (2000). Empowering couples: Prepare/enrich program. *Marriage and Family: A Christian Journal*, 3, 69-81.

Olson, D. H., Fournier, D. G., & Druckman, J. M. (1982). ENRICH: Enriching & nurturing the relationship issues, communication & happiness. *Journal of Marital and Family Therapy*, 8(1), 65–79.

Peterson, B. D., & Eifert, G. H. (2011). Using acceptance and commitment therapy to treat infertility stress. *Cognitive and Behavioral Practice*, 18(4), 577–587. doi:10.1016/ j.cbpra.2010.03.004

Peterson, B. D., Eifert, G. H., Feingold, T., & Davidson, S. (2009). Using acceptance and commitment therapy to treat distressed couples: A case study with two couples. *Cognitive and Behavioral Practice*, 16(4), 430–442. doi:10.1016/j.cbpra.2008.12.009

Pruitt, I. T., & McCollum, E. E. (2010). Voices of experience meditators: The impact of meditation practice on intimate relationships. *Contemporary Family Therapy*, 32(2), 135-154. doi:10.1007/s10591-009-9112-8

Rad, Y., Prudenzi, A., Zernerova, L., Gerson, J., & Flaxman, P. E. (2025). Effects of workplace acceptance and commitment therapy (ACT) programs on psychological flexibility's subprocesses: A systematic review. *Journal of Contextual Behavioral Science*, 37, 100915. doi:10.1016/j.jcbs.2025.100915

Rajabi, G., Imani, M., Khojasteh Mehr, R., Beirami, M., & Bashalidae, K. (2013). Efficacy of acceptance and commitment therapy and integrated behavioral couple therapy on the marital concern and adjustment of women with marital disturbance and generalized anxiety disorder. *Journal of Behavioral Sciences Research*, 11(6), 600-619 [Persian]. doi:20.1001.1.17352029.1392.11.6.10.1

Renshaw, K. D., & Caska-Wallace, C. M. (2025). Family-based management of OCD: An updated meta-analysis. *Clinical Child and Family Psychology Review*, 28(1), 1-22.

Spinhoven, P., Drost, J., de Rooij, M., van Hemert, A. M., & Penninx, B. W. (2014). A longitudinal study of experiential avoidance in emotional disorders. *Behavior Therapy*, 45(6), 840–850. doi:10.1016/j.beth.2014.07.001

Stockton, D., Kellett, S., & Patel, V. (2025). The active ingredients of ACT: A component network meta-analysis. *Behaviour Research and Therapy*, 185, 104550.

Strauss, A. M. (2012). The relationship between premarital sexual history and marital satisfaction for men [Master's thesis, George Mason University].

Treas, J., & Giesen, D. (2000). Sexual infidelity among married and cohabitating Americans. *Journal of Marriage and the Family*, 62(1), 48-60. doi:10.1111/j.1741-3737.2000.00048.x

Teymoori, R., Salmani, A. & Salehinejad, M. A. (2022). The relationship between emotional character with depression and anxiety in patients with polycystic ovary syndrome. *Journal of Research in Psychopathology*, *3*(7), 47-53. doi: 10.22098/jrp.2022.9595.1042

Twohig, M. P. (2004). ACT for OCD: *Abbreviated treatment manual*. University of Nevada.

Twohig, M. P., Morrison, K. L., & Bluett, E. J. (2014). Acceptance and commitment therapy for OCD and OC-spectrum disorders. *Current Psychiatry Reviews*, 10(4), 296–307. doi:10.2174/1573400510666140714172145

Twohig, M. P., Ong, C. W., & Levin, M. E. (2025). ACT for OCD and related disorders: A systematic review and future directions. *Journal of Anxiety Disorders*, 110, 102930.

Twohig, M. P., Plumb Vilardaga, J. C., Levin, M. E., & Hayes, S. C. (2015). Changes in psychological flexibility during acceptance and commitment therapy for obsessive compulsive disorder. *Journal of Contextual Behavioral Science*, 4(3), 196–202. doi:10.1016/j.jcbs.2015.07.001

Zanganeh Motlagh, F., Bani Jomali, S., Ahadi, H., & Hatami, H. R. (2017). The effectiveness of acceptance and commitment-based couple therapy and emotional couple therapy on improving intimacy and reducing couples' emotional failure. *Thought and Behavior*, 11(44), 47-91 [Persian].

Zarling, A., & Berta, M. (2017). An acceptance and commitment therapy approach for partner aggression. *Partner Abuse*, 8(1), 89-109. doi:10.1891/1946-6560.8.1.89