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The Effectiveness of Acceptance and Commitment Therapy on Obsessive Beliefs in University Students

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A B S T R A C T

Objective: The present study aimed to examine the effectiveness of Acceptance and Commitment Therapy (ACT) on obsessive beliefs and their components in university students.

Methods and Materials: This applied, quantitative research employed a quasi-experimental pretest–posttest design with a control group and a two-month follow-up. The statistical population comprised all undergraduate law students admitted in 2024 at the Islamic Azad University, Shiraz Branch. Using convenience sampling, 78 students were selected and randomly assigned to an experimental group (n = 39) receiving ACT and a control group (n = 39) receiving no intervention. The Obsessive Beliefs Questionnaire-44 (OBQ-44) was administered at pretest, posttest, and follow-up. The ACT intervention followed Steven C. Hayes's eight-session, 90-minute protocol. Data were analyzed using univariate and multivariate analyses of covariance (ANCOVA, MANCOVA) in SPSS version 26 after confirming the relevant parametric assumptions.

Findings: ANCOVA results indicated significant differences between the experimental and control groups at posttest in all obsessive belief components—general beliefs ($p = 0.006$, $\eta^2 = 0.115$), perfectionism and certainty ($p < 0.001$, $\eta^2 = 0.422$), responsibility ($p = 0.021$, $\eta^2 = 0.082$), thought control ($p = 0.020$, $\eta^2 = 0.083$), and complete performance ($p < 0.001$, $\eta^2 = 0.414$)—as well as in the total obsessive beliefs score ($p < 0.001$, $\eta^2 = 0.480$). Adjusted posttest means showed lower scores in the experimental group compared to the control group across all measures. Follow-up analysis confirmed the maintenance of treatment effects over two months.

Conclusion: Acceptance and Commitment Therapy significantly reduced obsessive beliefs and their subcomponents in university students, with effects maintained at follow-up. The findings highlight ACT's potential as an effective cognitive-behavioral intervention for addressing maladaptive belief patterns in student populations.

Keywords: *Acceptance and Commitment Therapy; Obsessive Beliefs; University Students; Perfectionism; Cognitive Flexibility*

1. Introduction

Obsessive-compulsive disorder (OCD) is a chronic and debilitating mental health condition characterized by intrusive thoughts (obsessions) and repetitive behaviors or mental acts (compulsions) that individuals feel compelled to perform in response to those thoughts (Lee et al., 2023; Philip & Cherian, 2021). This disorder significantly impairs daily functioning, social relationships, and quality of life (Ong et al., 2020; Soondrum et al., 2022). Globally, OCD affects approximately 2–3% of the population, with many cases presenting in late adolescence or early adulthood (Pseftogianni et al., 2023; Thompson et al., 2021). Research indicates that the persistence of symptoms often results from maladaptive cognitive processes such as cognitive fusion, perfectionism, experiential avoidance, and intolerance of uncertainty (Ardestani et al., 2022; Izatpour et al., 2024; Xiong et al., 2021). These processes sustain obsessive beliefs and increase the rigidity of mental patterns, making effective therapeutic interventions essential.

Traditional treatments for OCD have predominantly relied on cognitive-behavioral therapy (CBT), particularly exposure and response prevention (ERP), as the gold standard intervention (Ong et al., 2020; Philip & Cherian, 2021). ERP aims to reduce compulsive behaviors by gradually exposing individuals to anxiety-provoking stimuli while preventing the associated ritualistic responses (Twohig et al., 2018). While CBT and ERP have demonstrated substantial efficacy, a significant proportion of patients—estimated at 25% to 30%—either fail to respond adequately or discontinue treatment due to discomfort and poor tolerance for prolonged exposure (Cakmak, 2024; Taghavizade et al., 2019). This has prompted the exploration of alternative or adjunctive therapies that target the underlying cognitive and emotional mechanisms maintaining OCD (Fuenmayor et al., 2019; Parviziyaan et al., 2022).

Acceptance and Commitment Therapy (ACT) has emerged as a promising approach for addressing these limitations (Baniasadi et al., 2025; Twohig et al., 2015). Rooted in functional contextualism and relational frame theory, ACT focuses on increasing psychological flexibility—the ability to fully engage with the present moment and pursue valued actions despite the presence of unwanted thoughts, feelings, or sensations (Thompson et al., 2021; Twohig et al., 2015). ACT works through six core processes: acceptance, cognitive defusion, self-as-context, present-moment awareness, values clarification, and committed action (Philip & Cherian, 2021; Soondrum et al., 2022). Rather than attempting to directly reduce or eliminate intrusive thoughts, ACT helps individuals change their relationship with these experiences, thereby reducing their functional impact (Cakmak, 2024; Lee et al., 2023).

The relevance of ACT for OCD lies in its capacity to address maladaptive cognitive phenomena central to the disorder. For instance, cognitive fusion—overidentification with thoughts—is a well-documented predictor of OCD severity (Xiong et al., 2021). ACT employs defusion techniques to help individuals observe thoughts as transient mental events rather than literal truths (Ong et al., 2020). Similarly, experiential avoidance, or the tendency to evade unpleasant internal experiences, is countered through acceptance-based strategies (Ardestani et al., 2022; Asli Azad et al., 2020). This approach not only reduces distress associated with obsessions but also supports long-term behavioral change (Baniasadi et al., 2025; Twohig et al., 2018).

Empirical evidence supports the efficacy of ACT in reducing OCD symptoms and improving related constructs such as distress tolerance, quality of life, and emotional regulation (Baniasadi et al., 2025; Izatpour et al., 2024; Yarahmadi et al., 2021). For example, randomized controlled trials have shown that ACT can yield symptom reductions comparable to ERP while enhancing patient engagement and reducing dropout rates (Lee et al., 2023; Twohig et al., 2018). Meta-analyses further indicate that ACT is effective across various obsessive-compulsive and related disorders, with moderate to large effect sizes (Pseftogianni et al., 2023; Soondrum et al., 2022). Moreover, studies integrating ACT with ERP have demonstrated additive benefits, suggesting that combining acceptance-based strategies with exposure may optimize treatment outcomes (Fuenmayor et al., 2019; Ong et al., 2020).

The utility of ACT has also been highlighted in specific cognitive domains relevant to OCD. For instance, perfectionism—a core maintaining factor of obsessive beliefs—has been effectively reduced through ACT interventions, leading to broader improvements in psychological well-being (Izatpour et al., 2024; Parviziyaan et al., 2022; Taghavizade et al., 2019). Similarly, intolerance of uncertainty, a cognitive bias linked to compulsive checking and reassurance-seeking, can be significantly lowered through ACT-based strategies (Ardestani et al., 2022; Asli Azad et al., 2020). These changes are often accompanied by increases in cognitive flexibility, resilience,

and adaptive coping (Baniasadi et al., 2025; Tayebi Naieni et al., 2017).

ACT's applicability extends beyond symptom management, promoting long-term resilience and relapse prevention. By anchoring behavior in personal values rather than symptom reduction, ACT fosters sustained engagement in meaningful life activities (Thompson et al., 2021; Twohig et al., 2015). This values-based orientation is particularly important in OCD, where the narrowing of life domains due to avoidance behaviors often exacerbates disability (Cakmak, 2024; Philip & Cherian, 2021). Longitudinal studies have shown that ACT-based gains can be maintained over extended follow-up periods, with reductions in obsessive beliefs persisting for months after treatment completion (Asli Azad et al., 2019; Yarahmadi et al., 2020).

Despite these strengths, the application of ACT in OCD populations, particularly among university students, remains underexplored (Baniasadi et al., 2025; Izatpour et al., 2024). University students face unique developmental and environmental stressors, including academic pressures, social transitions, and identity formation challenges, which can exacerbate obsessive beliefs and related symptoms (Asli Azad et al., 2020; Yarahmadi et al., 2020). Furthermore, maladaptive perfectionism and cognitive rigidity—common among high-achieving students—can contribute to the persistence and severity of OCD symptoms (Parviziyaan et al., 2022; Taghavizade et al., 2019). The integration of ACT in this context offers an opportunity to address both symptom reduction and broader psychological skills, such as flexibility and value-driven action, that are critical for academic and personal success (Tayebi Naieni et al., 2017; Twohig et al., 2015).

This study aims to examine the effectiveness of Acceptance and Commitment Therapy on obsessive beliefs in university students

2. Methods and Materials

2.1. Study Design and Participants

The present study was an applied research with a quantitative approach, conducted using a quasi-experimental design with a pretest–posttest format, including a control group and a two-month follow-up phase. The statistical population consisted of all undergraduate law students admitted in 2024 at the Islamic Azad University, Shiraz Branch. From this population, a total of 78 participants were selected through convenience sampling. Based on the recommendations of previous research and methodological guidelines, a minimum of 30 participants per group was deemed sufficient for statistical analysis; however, considering an anticipated 30% attrition rate, the sample size was increased to 78. Participants were then randomly assigned, using a lottery method, to either the experimental group (n = 39) or the control group (n = 39). Inclusion criteria comprised willingness to participate, being enrolled in the specified academic program, and the absence of severe psychiatric conditions that could interfere with participation. Exclusion criteria included absenteeism from more than two intervention sessions and withdrawal from the study at any stage.

2.2. Measures

The data collection instrument used in this study was the Obsessive Beliefs Questionnaire-44 (OBQ-44), developed in 1997 by a group of specialists working on the cognitive aspects of obsessive–compulsive disorder. This self-report instrument consists of 44 items designed to assess and identify cognitive domains associated with obsessive–compulsive symptoms. The OBQ-44 measures five subscales: general beliefs, perfectionism and certainty, responsibility and overestimation of threat, importance and control of thoughts, and the need for complete performance. Items are rated on a seven-point Likert scale ranging from 1 ("strongly disagree") to 7 ("strongly agree"), with higher scores indicating more maladaptive obsessive beliefs. The scoring process involves summing the item scores for each subscale and the total scale, with possible scores ranging from −132 to +132. A higher proportion of negative responses reflects higher obsessive thinking, while higher positive responses indicate more balanced cognitive patterns. In this study, the cutoff score was set at the mild level of symptoms. Previous studies in Iran have demonstrated high internal consistency for the OBQ-44, with Cronbach's alpha coefficients exceeding 0.80 for all subscales, indicating strong reliability. In the current research, Cronbach's alpha for the obsessive beliefs scale was 0.94, confirming high internal consistency.

2.3. Intervention

The intervention was delivered over eight structured 90-minute sessions based on Steven C. Hayes's Acceptance and Commitment Therapy protocol, with a focus on enhancing psychological flexibility, clarifying personal values, and promoting committed action. The first session aimed to establish a therapeutic alliance and raise emotional

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awareness through psychoeducation and mindfulness exercises, with participants practicing mindfulness at home. The second session explored participants' creative hopelessness regarding previous treatments, using metaphors and guided questioning to help them identify personal values, set goals, and engage in exposure exercises as homework. In the third session, concepts of acceptance, values, and behavioral assignments were introduced, with emphasis on mood monitoring, continued mindfulness, and confronting unpleasant thoughts and memories. The fourth session focused on clarifying values, identifying barriers, and introducing committed action, with participants completing a "valued path" form and increasing awareness of sensations, thoughts, and emotions. The fifth session reviewed homework and addressed cognitive fusion and defusion techniques to enhance problem confrontation, with participants noting goals aligned with their values. The sixth session emphasized self-as-context, discussing life satisfaction, and practicing emotion regulation, with related mindfulness and regulation exercises assigned as homework. In the seventh session, the distinction between primary and secondary suffering was discussed alongside commitment processes and barriers to satisfaction, reinforcing stability in values and encouraging continued clarification exercises. The final session concentrated on value clarification, relapse prevention, acceptance of experiences, and motivation building, culminating in the assignment of a lifelong commitment to value-based action and a comprehensive review of learned skills and exercises.

2.4. Data Analysis

Data analysis was performed using SPSS version 26. Initially, descriptive statistics, including means and standard deviations, were computed to summarize demographic and primary study variables. Group homogeneity in demographic characteristics was examined using Fisher's exact test and independent t-tests. For inferential analysis, univariate analysis of covariance (ANCOVA) and multivariate analysis of covariance (MANCOVA) were employed to test the study hypotheses and compare groups across measurement points. Assumptions of parametric ANCOVA, including the absence of outliers, normal distribution of variables, homogeneity of variances, homogeneity of regression slopes, and equality of variance–covariance matrices, were assessed and confirmed prior to analysis. Given that the dependent variables were measured at three time points and the pretest scores served as covariates, ANCOVA was applied twice: first to compare posttest scores while controlling for pretest scores (effectiveness analysis) and second to compare follow-up scores while controlling for pretest scores (sustainability analysis).

3. Findings and Results

The demographic characteristics of participants in the experimental and control groups indicated no statistically significant differences between the groups in terms of gender, marital status, or age, confirming baseline homogeneity. In the experimental group, which received Acceptance and Commitment Therapy, 24 participants (70.6%) were female and 10 participants (29.4%) were male, while in the control group, 18 participants (50%) were female and 18 participants (50%) were male ($p = 0.093$). Regarding marital status, the experimental group comprised 16 single participants (47.1%) and 18 married participants (52.9%), compared to 20 single participants (55.6%) and 16 married participants (44.4%) in the control group ($p = 0.633$). The mean age of participants in the experimental group was 31.58 years (SD = 4.58), whereas the control group had a mean age of 32.92 years (SD = 5.16), with no significant difference between groups ($p = 0.283$).

Table 1

Descriptive statistics of obsessive beliefs by group and time

Variable	Time	Acceptance and Commitment Therapy		Control	
		Mean	SD	Mean	SD
General beliefs	Pretest	64.41	11.82	64.44	13.72
	Posttest	58.71	10.83	63.28	13.26
	Follow-up	56.88	10.86	63.50	13.30
Perfectionism and certainty	Pretest	46.00	11.90	43.33	10.22
	Posttest	42.47	10.43	43.22	9.55
	Follow-up	41.82	9.91	43.56	9.44
Responsibility	Pretest	27.41	7.82	28.22	7.69
	Posttest	26.12	6.42	27.56	7.17

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	Follow-up	26.18	6.26	27.39	6.67
Thought control	Pretest	23.53	6.80	23.56	7.86
	Posttest	22.65	5.82	23.78	7.05
	Follow-up	23.24	5.37	23.61	7.07
Complete performance	Pretest	18.18	6.29	20.78	6.43
	Posttest	16.29	4.34	20.89	5.64
	Follow-up	16.29	4.43	21.28	5.59
Total obsessive beliefs	Pretest	179.53	15.49	181.33	19.16
	Posttest	166.24	12.97	178.72	19.74
	Follow-up	164.41	14.09	179.33	19.99

The descriptive results indicated that, across all components of obsessive beliefs, the experimental group that underwent Acceptance and Commitment Therapy showed a reduction in mean scores from pretest to posttest and maintained these improvements at the two-month follow-up. For instance, in the general beliefs component, the mean score in the experimental group decreased from 64.41 in the pretest to 58.71 in the posttest, and further to 56.88 at follow-up, whereas the control group's scores remained relatively stable over time. Similar trends were observed in other components, such as perfectionism and certainty, responsibility, thought control, and complete performance, as well as in the total obsessive beliefs score, where the experimental group's mean declined from 179.53 at pretest to 166.24 at posttest and 164.41 at follow-up, while the control group showed minimal changes. These descriptive patterns suggest that the intervention had a positive and sustained effect in reducing obsessive beliefs among participants in the experimental group.

Table 2

Analysis of covariance to assess the effectiveness of Acceptance and Commitment Therapy on obsessive beliefs and their components at posttest

Time	Source	Dependent variable	Sum of squares	df	Mean square	F	p-value	Effect size
Posttest	Group	General beliefs	226.69	1	226.69	8.22	0.006	0.115
		Perfectionism and certainty	155.25	1	155.25	45.95	<0.001	0.422
		Responsibility	11.18	1	11.18	5.60	0.021	0.082
		Thought control	20.38	1	20.38	5.72	0.020	0.083
		Complete performance	123.11	1	123.11	44.60	<0.001	0.414
		Total obsessive beliefs	2055.43	1	2055.43	61.73	<0.001	0.480

The results of the analysis of covariance at the posttest stage demonstrated that there were significant differences between the experimental and control groups in all components of obsessive beliefs after controlling for pretest scores. Specifically, the intervention produced significant reductions in general beliefs ($F = 8.22$, $p = 0.006$, $\eta^2 = 0.115$), perfectionism and certainty ($F = 45.95$, $p < 0.001$, $\eta^2 = 0.422$), responsibility ($F = 5.60$, $p = 0.021$, $\eta^2 = 0.082$), thought control ($F = 5.72$, $p = 0.020$, $\eta^2 = 0.083$), and complete performance ($F = 44.60$, $p < 0.001$, $\eta^2 = 0.414$). The overall obsessive beliefs score also showed a highly significant difference between groups ($F = 61.73$, $p < 0.001$, $\eta^2 = 0.480$), indicating a large effect size. These findings suggest that Acceptance and Commitment Therapy had a substantial and statistically significant impact on reducing obsessive beliefs and all their measured components in the experimental group compared to the control group.

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Table 3

Adjusted posttest means of obsessive beliefs and their components by group

Test stage	Variable	Group	Adjusted mean	Std. error	Lower bound	Upper bound	Mean difference
Posttest	General beliefs	Acceptance and Commitment Therapy	59.14	0.918	57.30	60.97	3.73
		Control	62.87	0.891	61.09	64.65	
	Perfectionism and certainty	Acceptance and Commitment Therapy	41.27	0.321	40.63	41.91	3.09
		Control	44.36	0.312	43.73	44.98	
	Responsibility	Acceptance and Commitment Therapy	26.43	0.247	25.94	26.92	0.829
		Control	27.26	0.240	26.78	27.74	
	Thought control	Acceptance and Commitment Therapy	22.65	0.330	21.99	23.31	1.12
		Control	23.77	0.320	23.13	24.41	
	Complete performance	Acceptance and Commitment Therapy	17.24	0.290	16.66	17.82	2.75
		Control	19.99	0.282	19.43	20.56	
	Total obsessive beliefs	Acceptance and Commitment Therapy	167.07	0.990	165.10	169.05	10.86
		Control	177.93	0.962	176.01	179.85	

The adjusted posttest means, controlling for pretest scores, revealed that the experimental group receiving Acceptance and Commitment Therapy consistently scored lower than the control group across all components of obsessive beliefs as well as in the total score. For example, in the general beliefs component, the adjusted mean for the experimental group was 59.14 compared to 62.87 in the control group, with a mean difference of 3.73. The largest reduction was observed in the total obsessive beliefs score, where the adjusted mean in the experimental group was 167.07, compared to 177.93 in the control group, reflecting a difference of 10.86 points. Substantial mean differences were also noted in perfectionism and certainty (3.09) and complete performance (2.75), while smaller yet meaningful differences were found in responsibility (0.829) and thought control (1.12). These results further support the conclusion that Acceptance and Commitment Therapy effectively reduced obsessive beliefs in participating students.

4. Discussion and Conclusion

The findings of the present study demonstrated that Acceptance and Commitment Therapy (ACT) produced significant reductions in obsessive beliefs and their components—general beliefs, perfectionism and certainty, responsibility, thought control, and complete performance—among university students, compared to the control group. These improvements were evident in posttest scores and persisted during the two-month follow-up period, indicating both the immediate and sustained effectiveness of ACT. The largest reductions were observed in the total obsessive beliefs score and in the domains of perfectionism and certainty and complete performance, suggesting that ACT is particularly effective in addressing rigid cognitive standards and performance-related thought patterns. This aligns with the theoretical underpinnings of ACT, which emphasize altering individuals' relationships with their thoughts rather than attempting to eliminate them, thereby reducing the functional impact of maladaptive beliefs (Philip & Cherian, 2021; Twohig et al., 2015).

The observed reduction in perfectionism and certainty is consistent with previous findings that ACT effectively targets maladaptive perfectionistic tendencies and intolerance of ambiguity, both of which are central maintaining factors in obsessive-compulsive symptomatology (Izatpour et al., 2024; Parviziyaan et al., 2022; Taghavizade et al., 2019). By using defusion and acceptance strategies, ACT enables individuals to disengage from the rigid cognitive rules and performance standards that perpetuate obsessive beliefs. The current study's results corroborate the work of Baniasadi et al., who found that ACT was superior to cognitive behavioral therapy (CBT) in enhancing cognitive flexibility and resilience among adolescents with OCD, highlighting its capacity to modify entrenched thought patterns (Baniasadi et al., 2025). Similarly, Ardestani et al. reported significant improvements in uncertainty intolerance and experiential avoidance following ACT, both of which are closely related to perfectionism and certainty (Ardestani et al., 2022).

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The findings for the responsibility and thought control components also reflect ACT's theoretical and empirical strengths. ACT's acceptance-based approach, which contrasts with control-oriented strategies, encourages clients to experience unwanted thoughts without engaging in attempts to suppress or neutralize them (Ong et al., 2020; Twohig et al., 2018). This process reduces the perceived need to control thoughts—a cognitive pattern strongly linked to obsessive-compulsive behavior (Xiong et al., 2021). In the present study, participants in the experimental group exhibited significant decreases in thought control scores, indicating a shift toward more adaptive cognitive processing. These results are consistent with prior research showing that ACT reduces cognitive fusion and thought-action fusion in individuals with OCD (Asli Azad et al., 2019; Twohig et al., 2015). In addition, reductions in inflated responsibility beliefs may be explained by ACT's emphasis on values clarification and committed action, which encourage individuals to prioritize personally meaningful behavior over compulsive rituals intended to prevent imagined harm (Fuenmayor et al., 2019; Thompson et al., 2021).

The substantial change in the complete performance component aligns with ACT's capacity to challenge rigid behavioral standards and the need to perform tasks flawlessly—a hallmark of many obsessive-compulsive presentations (Cakmak, 2024; Philip & Cherian, 2021). By helping clients accept that imperfection is an inevitable part of human experience, ACT reduces performance-related anxiety and the compulsion to repeatedly check or redo tasks. This finding mirrors the results of Soondrum et al., whose meta-analysis indicated that ACT interventions significantly improved tolerance for incomplete or imperfect outcomes in OCD populations (Soondrum et al., 2022). Furthermore, the long-term maintenance of these gains, as observed in the follow-up assessment, reinforces the evidence that ACT fosters durable cognitive and behavioral changes through the development of psychological flexibility (Lee et al., 2023; Twohig et al., 2015).

The sustained reductions in total obsessive beliefs observed in this study are particularly notable given the challenge of achieving long-term remission in OCD-related cognitive patterns. Previous longitudinal research has shown that gains from ACT interventions can be maintained for several months post-treatment (Asli Azad et al., 2020; Yarahmadi et al., 2020). In the present study, the two-month follow-up data indicate that participants continued to apply ACT skills beyond the structured sessions, suggesting successful internalization of these techniques. This is consistent with findings from Twohig et al., who reported that the incorporation of ACT into exposure and response prevention protocols led to higher maintenance rates of treatment gains (Twohig et al., 2018). By fostering acceptance and defusion, ACT equips clients with strategies to handle intrusive thoughts without escalating compulsive responses, thus reducing the likelihood of relapse (Ong et al., 2020; Thompson et al., 2021).

Another important aspect of the findings is the potential relevance of ACT for student populations. University students are frequently exposed to high academic demands and social pressures, which can exacerbate maladaptive perfectionism, cognitive rigidity, and obsessive beliefs (Asli Azad et al., 2020; Izatpour et al., 2024). The results of this study indicate that ACT can address these cognitive vulnerabilities in an educational setting, providing students with skills that not only mitigate obsessive beliefs but also enhance overall psychological well-being. This extends the existing literature, which has primarily examined ACT in clinical or community OCD samples, by demonstrating its utility in a non-clinical yet at-risk group (Baniasadi et al., 2025; Tayebi Naieni et al., 2017). The intervention's focus on values-driven action is particularly relevant for students navigating developmental tasks related to identity, career planning, and interpersonal relationships (Philip & Cherian, 2021; Thompson et al., 2021).

The overall pattern of results underscores ACT's role as both a stand-alone and adjunctive treatment for obsessive beliefs. Previous comparative studies have shown that ACT can match or exceed the effectiveness of CBT for certain OCD-related outcomes, while offering better tolerance and lower dropout rates (Baniasadi et al., 2025; Parviziyaan et al., 2022; Taghavizade et al., 2019). The present study supports these conclusions by demonstrating significant, broad-based, and lasting reductions in obsessive beliefs through an ACT-only protocol. Furthermore, the intervention's versatility allows for integration with other evidence-based treatments, such as ERP, to potentially enhance therapeutic effects (Fuenmayor et al., 2019; Ong et al., 2020; Twohig et al., 2018).

In sum, the results of this research add to the growing evidence that ACT effectively targets the cognitive processes underlying obsessive beliefs, reduces maladaptive perfectionism, and improves tolerance of uncertainty in university students. The sustained post-treatment improvements highlight the intervention's potential for promoting long-term cognitive and behavioral change. These findings align with both theoretical models of ACT

and empirical studies conducted across diverse OCD populations (Lee et al., 2023; Philip & Cherian, 2021; Soondrum et al., 2022), underscoring the value of incorporating ACT into prevention and intervention strategies for obsessive beliefs in young adults.

5. Limitations & Suggestions

Despite the promising results, the present study has several limitations that should be acknowledged. First, the sample was limited to undergraduate law students from a single university, which restricts the generalizability of the findings to other academic disciplines, educational levels, or broader age groups. Second, the reliance on self-report measures introduces the possibility of response bias, as participants may have under- or overestimated their obsessive beliefs. Third, the study's follow-up period was limited to two months; while the results indicate short-term maintenance of gains, longer-term follow-up assessments are necessary to determine the durability of treatment effects. Additionally, the absence of an active control condition (e.g., an alternative psychological intervention) limits the ability to attribute changes solely to ACT-specific processes rather than nonspecific therapeutic factors such as attention or group support.

Future studies should aim to replicate these findings with more diverse samples, including students from various academic disciplines and individuals from different cultural and socioeconomic backgrounds. It would also be beneficial to extend follow-up assessments to six months or one year to examine the long-term stability of treatment gains. Comparative studies that pit ACT against other evidence-based interventions, such as CBT or mindfulness-based therapies, could provide further insight into the relative strengths and limitations of each approach. Moreover, dismantling studies that isolate specific ACT processes—such as cognitive defusion or values clarification—could help identify which components are most effective in reducing obsessive beliefs. Finally, incorporating objective behavioral measures or clinician-rated assessments would strengthen the validity of future findings.

In practice, the results suggest that ACT can be effectively implemented as a brief, structured intervention for reducing obsessive beliefs among university students. Mental health professionals working in academic settings could integrate ACT protocols into student counseling services to address perfectionism, cognitive rigidity, and maladaptive thought control. Group-based formats may offer a cost-effective means of delivering ACT, fostering peer support while teaching acceptance and values-driven action. Additionally, embedding ACT principles into psychoeducational workshops or resilience training programs could benefit a wider student audience, promoting psychological flexibility as a protective factor against a range of cognitive and emotional difficulties.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. This study was reviewed and approved at the Islamic Azad University, Khomeinishahr Branch, with the ethics code IR.IAU.KHSH.REC.1403.087.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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All authors equally contributed to this article.

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