

The Effectiveness of Unified Transdiagnostic Therapy on Experiential Avoidance, Cognitive Fusion, and Self-Conscious Emotions in Patients with Obsessive-Compulsive Disorder

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Abstract

Background: Obsessive-compulsive disorder (OCD) is characterized by intrusive thoughts and maladaptive emotional responses that significantly impair daily functioning.

Objectives: This study aimed to evaluate the effectiveness of Unified Transdiagnostic Therapy (UTT) in reducing experiential avoidance, cognitive fusion, and self-conscious emotions in patients diagnosed with OCD.

Methods: A quasi-experimental design with pre-test, post-test, and control group was employed. The statistical population comprised 65 patients referred to psychological clinics and medical centers in Ardabil City in 2024. From this population, 36 patients diagnosed with OCD were selected via convenience sampling and randomly assigned to either the experimental (n = 18) or control (n = 18) group. The experimental group received eight 90-minute sessions of UTT. Data were collected using the Obsessive-Compulsive Disorder Questionnaire (OCDQ), the Acceptance and Action Questionnaire (AAQ-II), the Cognitive Fusion Questionnaire (CFQ), and the Test of Self-Conscious Affect (TOSCA-3). Statistical analyses were conducted using multivariate analysis of covariance (MANCOVA) in SPSS version 27.

Results: The findings demonstrated that UTT significantly reduces experiential avoidance ($F = 86.36, \eta^2 = 0.74$), cognitive fusion ($F = 81.91, \eta^2 = 0.73$), shame ($F = 65.92, \eta^2 = 0.68$), and guilt ($F = 76.21, \eta^2 = 0.72$) in patients with OCD ($P < 0.01$).

Conclusion: This study underscores the efficacy of UTT as a transdiagnostic intervention for ameliorating the maladaptive cognitive and emotional processes prevalent in OCD. By fostering enhanced psychological flexibility and emotional regulation, UTT constitutes a viable and practical therapeutic option. These findings support the broader application of transdiagnostic approaches in targeting the fundamental mechanisms underpinning a range of emotional disorders.

Keywords: Unified Transdiagnostic Therapy, Experiential Avoidance, Cognitive Fusion, Self-Conscious Emotions, Obsessive-Compulsive Disorder

1. Background

Patients with Obsessive-Compulsive Disorder (OCD) experience persistent and intrusive thoughts, images, or urges (obsessions) that generate significant anxiety, accompanied by repetitive behaviors or mental acts (compulsions) performed to mitigate distress (1). OCD is a

chronic and often debilitating psychiatric condition affecting individuals across all age groups and cultures, markedly impairing daily functioning, social relationships, and overall quality of life (2). Despite increased awareness, OCD is frequently underdiagnosed or misunderstood, resulting in treatment delays and prolonged suffering (3). Stein et al. (4) reported that

across ten surveyed countries, the lifetime prevalence of OCD was 4.1%, while the 12-month prevalence was 3.0%. The narrow margin between lifetime and 12-month prevalence rates suggests that OCD typically follows a persistent, chronic trajectory once established.

Experiential avoidance denotes an individual's efforts to escape, suppress, or control unwanted internal experiences—such as intrusive thoughts, distressing emotions, bodily sensations, or memories (5, 6). In patients with OCD, experiential avoidance constitutes a central psychological process that perpetuates symptom severity. Individuals with OCD frequently perceive intrusive thoughts as intolerable and threatening, prompting them to engage in strategies aimed at preventing or eliminating these experiences (7). Although avoidance may yield temporary relief, it paradoxically reinforces the frequency and intensity of obsessive thoughts over time (8). Within the context of OCD, compulsive behaviors and mental rituals serve as prominent forms of experiential avoidance (6). Actions such as repetitive washing, checking, reassurance seeking, or mental neutralization are performed to circumvent the anxiety, guilt, or perceived responsibility associated with obsessions (9).

Cognitive fusion describes a psychological state wherein individuals become overly entangled with their thoughts, treating them as literal truths rather than transient mental events (10, 11). In OCD, cognitive fusion is particularly pronounced, as patients tend to interpret intrusive thoughts as meaningful, dangerous, or indicative of personal culpability (12). Beliefs such as "having a thought means I will act on it" or "thinking something bad makes it more likely to happen" exemplify fusion-based cognitive patterns (13). This rigid adherence to

obsessive thoughts markedly amplifies emotional distress and propels compulsive behavior (10). When individuals are cognitively fused, intrusive thoughts evoke intense fear, guilt, or disgust, thereby heightening the urgency to neutralize or suppress them (14).

Self-conscious emotions, including shame, guilt, and embarrassment, are highly salient in the phenomenological experience of OCD (15, 16). Many patients report profound moral distress associated with the content of their obsessions, particularly in cases involving aggressive, sexual, or religious themes (17). These emotions arise not from actual behavior but from perceived transgressions of personal or societal standards triggered by intrusive thoughts (18). Excessive guilt and shame contribute to maladaptive coping strategies and the persistence of OCD symptoms (16). Patients may resort to compulsions to neutralize feelings of moral transgression or to restore a sense of personal integrity (19).

Unified Transdiagnostic Therapy (UTT) is a flexible approach targeting multiple emotional disorders concurrently and has garnered increasing recognition as an effective treatment modality for OCD (20). In contrast to disorder-specific treatments, UTT addresses the shared emotional and cognitive mechanisms underlying OCD and related emotional disturbances (21). Given that OCD is characterized by heightened emotional reactivity, maladaptive emotion regulation, and persistent avoidance of distressing internal experiences, a transdiagnostic approach provides a comprehensive framework for addressing the core processes that sustain the disorder (22). One primary mechanism through which UTT affects OCD involves the reduction of experiential avoidance and the enhancement of emotional tolerance (23). Patients with OCD frequently engage in compulsions to escape the anxiety, guilt, or

fear associated with intrusive thoughts (24). UTT emphasizes emotional awareness, acceptance, and exposure to emotional experiences without avoidance, thereby enabling patients to learn that distress is both tolerable and transient (25). This paradigm shift attenuates reliance on compulsive behaviors and fosters adaptive coping strategies (26). Furthermore, UTT addresses maladaptive cognitive processes—such as cognitive fusion and rigid threat appraisals—which play a central role in the maintenance of OCD (27). Through cognitive flexibility and mindful awareness techniques, patients learn to observe obsessive thoughts without interpreting them as dangerous or as meaningful predictors of action or intent (28). This decoupling of thought from behavior reduces the perceived necessity to neutralize obsessions, consequently diminishing symptom severity (29).

OCD is a chronic and often disabling condition with profound clinical significance due to its pervasive impact on personal, social, and occupational functioning. The disorder is frequently accompanied by elevated levels of distress, shame, and diminished quality of life. Characterized not only by intrusive obsessions and compulsive behaviors but also by persistent difficulties in emotional regulation, excessive responsibility, and maladaptive responses to internal experiences, OCD contributes to treatment resistance and a heightened risk of relapse. Given the extensive impact of OCD and its intricate cognitive and emotional underpinnings, investigating therapeutic approaches that extend beyond mere symptom reduction to target the core maintaining processes is essential.

2. Objective

This study aimed to evaluate the effectiveness of UTT in reducing experiential avoidance, cognitive fusion, and self-conscious emotions among

patients diagnosed with OCD.

3. Methods

The present study utilized a quasi-experimental design featuring pre-test, post-test, and a control group. The statistical population consisted of 65 patients referred to psychological clinics and medical centers in Ardabil City in 2024, recruited via convenience sampling. To identify patients with OCD, the Obsessive-Compulsive Disorder Questionnaire (OCDQ; 30) was administered to all 65 participants. Patients scoring below 100 on the OCDQ were considered eligible for the final sample. From this group, 36 patients meeting the diagnostic criteria for OCD were selected. Based on a power analysis conducted using G*Power software (31), 18 participants were allocated to each group. Participants were subsequently randomly assigned to either the experimental ($n = 18$) or the control ($n = 18$) group. Inclusion criteria comprised personal consent, an OCDQ score below 100, an age range of 18 to 50 years, and the absence of musculoskeletal disorders. Exclusion criteria included missing more than two therapy sessions, submitting incomplete questionnaire responses, or exhibiting an exacerbation of OCD symptoms. Ethical considerations were rigorously observed, including the procurement of informed consent, the maintenance of confidentiality, and adherence to the principles outlined in the Declaration of Helsinki.

3.1. Data Collection

3.1.1. Obsessive-Compulsive Disorder Questionnaire (OCDQ)

Developed by Sanavio (30) in Italy, this 60-item instrument assesses the severity of OCD symptoms in both clinical and non-clinical populations. Each item is rated on a scale of 0 to 4 based on the degree of disturbance it elicits. The Padua Inventory, a self-report measure, distinguishes between

the characteristics of obsessive thoughts and the manifestations of practical obsessions (30). Content validity was established via the Content Validity Index (CVI=0.90) and Content Validity Ratio (CVR=0.84), collectively indicating satisfactory content validity. The Cronbach's alpha coefficient for this scale was 0.85, demonstrating robust internal consistency reliability.

3.1.2. The Acceptance and Action Questionnaire (AAQ)

Developed by Bond et al. (32), this 16-item instrument is derived from Hayes' original scale designed to measure experiential avoidance and psychological inflexibility. Items are rated on a 7-point Likert scale ranging from 1 (never true) to 7 (always true), with items 1, 4, and 16 reverse-scored. Total scores range from 16 to 112, with higher scores reflecting greater experiential avoidance and diminished psychological flexibility. Psychometric evaluations of the original version, based on data from 2,010 participants across six samples, demonstrated satisfactory internal consistency (mean Cronbach's alpha = 0.84), adequate test-retest reliability over 3- and 12-month intervals ($r=0.81$), and strong construct and discriminant validity. Evidence suggests that the second version assesses a conceptually similar construct while exhibiting improved psychometric stability (32). In the present study, content validity was confirmed (CVI=0.89, CVR=0.81), and reliability was substantiated by a Cronbach's alpha coefficient of 0.81.

3.1.3. The Cognitive Fusion Questionnaire (CFQ)

Developed by Gillanders et al. (33), this 12-item self-report measure assesses the degree to which individuals become entangled with their thoughts and internal experiences. Items are rated on a 6-point Likert scale ranging from 1 (never) to 6 (always), yielding total scores between 12

and 72, with higher scores indicating greater cognitive fusion and heightened engagement with intrusive or dysfunctional thoughts. In the original validation study (33) conducted with a sample of 1,040 students, the instrument exhibited excellent internal consistency (Cronbach's alpha=0.93) and satisfactory four-week test-retest reliability ($r=0.80$). In the present study, content validity was established (CVI=0.92, CVR=0.88), and the Cronbach's alpha coefficient was 0.89.

3.1.4. The Test of Self-Conscious Affect-3 (TOSCA-3)

Developed by Tangney and Dearing (34), this instrument assesses proneness to shame and guilt. It evaluates emotional, cognitive, and behavioral responses associated with the tendency to experience shame and guilt across various scenarios and includes subscales measuring externalization, detachment/unconcern, shame, alpha pride (pride in self), and beta pride (pride in behavior). The final version comprises 70 items presented across 16 scenarios (11 positive and 5 negative), with responses rated on a 5-point Likert scale ranging from 1 (not likely) to 5 (very likely). Evidence for construct validity indicates that the shame-proneness subscale correlates positively and significantly with nine dimensions of the SCL-90-R, with correlation coefficients ranging from 0.20 to 0.40 (34). In the present study, content validity was established (CVI = 0.89, CVR = 0.82). Regarding reliability, Cronbach's alpha coefficients were 0.82 for the shame subscale and 0.87 for the guilt subscale.

3.1.5. Unified Transdiagnostic Therapy (UTT)

As delineated by Ehrenreich-May et al. (35), UTT is a structured yet flexible therapeutic approach designed to target the shared mechanisms underlying emotional disorders. The intervention comprises eight modules, typically delivered across 11 weekly 90-minute sessions (Table 1). UTT

integrates core principles of cognitive-behavioral therapy with advances in emotion regulation research, emphasizing skills such as mindfulness, cognitive restructuring, emotional exposure, and behavioral activation. By addressing transdiagnostic factors—including cognitive distortions and emotional dysregulation—UTT enhances emotional awareness, cultivates adaptive coping strategies, and

improves overall psychological functioning. Its flexibility and individualized methodology render it an effective intervention for a broad spectrum of emotional disorders (35). The present study investigates the effectiveness of UTT on experiential avoidance, cognitive fusion, and self-conscious emotions in patients diagnosed with OCD.

Table 1. Summary of Unified Protocol for Transdiagnostic Treatment

Session	Goal	Content
1	Building and Maintaining Motivation	Establish a supportive therapeutic relationship; set concrete goals related to self-harm or experiential avoidance; encourage behavior change; and discuss the pros and cons of change.
2–3	Identifying Emotions and Behaviors	Educate about different emotions; practice emotion recognition; explore the functional purpose of emotions; map emotional experiences; examine the role of avoidance in perpetuating emotional cycles; and understand personal emotional response patterns.
4	Introducing Emotion-Focused Behavioral Experiments	Introducing Emotion-Focused Behavioral Experiments Teach adaptive behaviors as alternatives to maladaptive responses; conduct behavioral experiments to demonstrate the feasibility of adaptive behaviors; focus on alternatives to self-harm or compulsive behaviors; and identify pleasurable daily activities.
5	Awareness of Physical Sensations	Increase awareness of bodily responses to intense emotions; teach interoceptive exposure to facilitate adaptation to strong physical sensations; and practice tolerating these sensations until the body returns to a relaxed state.
6–7	Flexibility in Thinking	Assist patients in interpreting ambiguous situations more flexibly; differentiate between logical and illogical thoughts; introduce cognitive distortions; and teach problem-solving and coping strategies for anxiety or compulsive urges.
8	Awareness of Emotional Experiences	Enhance present-moment emotional awareness; practice mindfulness and non-judgmental awareness; identify subtle avoidance behaviors; and conduct controlled emotional exposures.
9–10	Situational Emotion Exposure	Review previously acquired skills; identify situations wherein the patient engages in experiential avoidance, cognitive fusion, or maladaptive behaviors; and practice applying adaptive strategies.
11	Reviewing Achievements and Future Planning	Review learned skills; solicit patient feedback; emphasize effective strategies; and plan for future stressors and emotional challenges to prevent relapse of OCD symptoms or avoidance behaviors.

3.1.6. Statistical Analyses

Upon collection, all research data were entered into SPSS software version 27. Multivariate Analysis of Covariance

(MANCOVA) was employed to analyze the scores. The significance level for testing the assumptions was set at 0.05.

4. Results

The mean age of patients with OCD was 29.38 years (SD = 4.80) in the experimental group and 28.87 years (SD = 4.59) in the

control group. A chi-square test was employed to examine demographic information among patients with OCD, with the results reported in Table 2.

Table 2: Demographic Information of Participants

Gender	Experimental Group		Control Group		Chi-square (P-value)
	Frequency	Percentage	Frequency	Percentage	
Female	12	66.6	11	61.1	P=>0.162
Male	6	33.4	7	38.9	
Marital status	Frequency	Percentage	Frequency	Percentage	Chi-square (P-value)
	Married	7	38.9	8	
Single	11	61.1	10	55.6	
Education	Frequency	Percentage	Frequency	Percentage	Chi-square (P-value)
	Diploma	5	27.7	6	
Bachelor	10	55.6	9	50.0	P=>0.102
Masters	3	16.6	3	16.6	

The chi-square test results indicated no significant differences between the experimental and control groups regarding gender, marital status, or education (P > 0.05). The mean and standard deviation (SD) of pre-test and post-test scores for experiential avoidance, cognitive fusion, and self-conscious emotions in both groups

are presented in Table 3. Additionally, this table reports the Shapiro-Wilk (S-W) test results for assessing the normality of variable distributions within the two groups. As the S-W test was non-significant for all variables, it can be concluded that the distributions approximate normality (Table 3).

Table 3: Descriptive Indices of the Study Variables in Control and Experimental Groups

Variables	Stage	Groups	Mean	SD	S-W	p*
OCD	Pre-test	Experimental	169.21	2.61	0.098	0.057
		Control	168.36	2.57	0.101	0.061
	Post-test	Experimental	147.55	2.39	0.098	0.070
		Control	169.74	2.10	0.104	0.059
Experiential Avoidance	Pre-test	Experimental	32.55	1.89	0.107	0.052
		Control	32.11	1.52	0.099	0.067
	Post-test	Experimental	27.16	1.74	0.114	0.055
		Control	33.27	1.62	0.103	0.063
Cognitive Fusion	Pre-test	Experimental	35.61	1.59	0.105	0.064
		Control	35.12	1.90	0.090	0.051
	Post-test	Experimental	30.05	1.69	0.106	0.069
		Control	36.23	1.50	0.118	0.070
Shame	Pre-test	Experimental	40.72	2.87	0.119	0.077
		Control	40.39	2.01	0.101	0.060
	Post-test	Experimental	34.45	2.74	0.094	0.052
		Control	42.05	1.87	0.100	0.068
Guilt	Pre-test	Experimental	58.61	1.80	0.089	0.053
		Control	58.05	1.47	0.093	0.064
	Post-test	Experimental	51.89	1.25	0.097	0.069
		Control	59.88	1.94	0.089	0.052

* Shapiro-Wilk test

MANCOVA was utilized to evaluate the efficacy of UTT on experiential avoidance, cognitive fusion, and self-conscious emotions in patients with OCD. Levene's test results for examining the homogeneity of variance of dependent variables across groups indicated that the variances for experiential avoidance, cognitive fusion, and self-conscious emotions were equal across groups ($P > 0.05$). Box's M test results for assessing the equality of the covariance matrices of dependent variables between the experimental and control groups also demonstrated that the covariance matrices were equal (Box's M = 18.92, $F = 1.63$, $P = 0.087$).

The non-significance of Box's M test ($P > 0.05$) confirms that this assumption is tenable. Furthermore, the results of the Bartlett's test of sphericity (Chi-square)

examining the significance of the relationships among experiential avoidance, cognitive fusion, and self-conscious emotions were significant ($\chi^2 = 117.36$, $df = 21$, $P < 0.05$). Another crucial assumption for MANCOVA is the homogeneity of regression slopes. This assumption was examined through the interaction between dependent variables and the independent variable (intervention method) across pre-test and post-test scores. The interaction between pre-test/post-test scores and the independent variable was non-significant, indicating homogeneity of regression slopes; thus, this assumption was also satisfied. Given that all assumptions for MANCOVA were met, the test was deemed appropriate for use. Subsequently, MANCOVA was performed to identify group differences (Table 4).

Table 4: Results of Multivariate Analysis of Covariance on Mean Post-Test Scores

Test	Value	F	df	Error df	P	Effect Value
Pillai's Trace	0.769	22.47	4	27	<0.001	0.76
Wilks Lambda	0.231	22.47	4	27	<0.001	0.76
Hotelling Trace	3.330	22.47	4	27	<0.001	0.76
Roy's Largest Root	3.330	22.47	4	27	<0.001	0.76

According to Table 4, the results demonstrate a significant effect of the independent variable on the combined dependent variables. Specifically, the experimental and control groups differ significantly in at least one of the variables of experiential avoidance, cognitive fusion, and self-conscious emotions. Based on the calculated effect size, 76% of the total variance between the experimental and

control groups is attributable to the independent variable. The statistical power of the test was equal to 1, indicating the adequacy of the sample size. To determine precisely which areas exhibited significant differences, univariate analysis of covariance tests was conducted within the MANCOVA framework; these results are reported in Table 5.

Table 5: Results of Univariate Analysis of Covariance on the Mean of Post-Test Scores of Dependent Variables in Experimental and Control Groups

Variables	SS	SS Error	DF	MS	MS Error	F	P	Effect Value
Experiential Avoidance	321.77	111.77	1	321.77	3.72	86.36	<0.001	0.74
Cognitive Fusion	350.68	128.43	1	350.68	4.28	81.91	<0.001	0.73
Shame	495.93	225.71	1	495.93	7.52	65.92	<0.001	0.68
Guilt	552.50	217.51	1	552.50	7.25	76.21	<0.001	0.72

Based on the results presented in Table 5, the F statistic is significant for experiential avoidance ($F=86.36$), cognitive fusion ($F=81.91$), shame ($F=65.92$), and guilt ($F=76.21$) at the 0.001 level. These findings indicate significant differences between the groups across all four variables. Furthermore, based on the partial eta squared values, 74% of the variance in experiential avoidance, 73% of the variance in cognitive fusion, 68% of the variance in shame, and 72% of the variance in guilt can be attributed to the independent variable (intervention). Consequently, it can be concluded that UTT significantly reduces experiential avoidance, cognitive fusion, and self-conscious emotions in patients with OCD.

5. Discussion

The primary objective of this study was to assess the effectiveness of UTT in alleviating experiential avoidance, cognitive fusion, and self-conscious emotions among patients with OCD. The results demonstrated that UTT led to a significant reduction in experiential avoidance. Prior to the intervention, participants frequently attempted to suppress, control, or avoid distressing internal experiences—such as intrusive thoughts and anxiety—which served to reinforce compulsive behaviors. Post-intervention assessments revealed that patients reported substantially less avoidance, indicating that the therapy successfully fostered confrontation with uncomfortable internal states rather than escape or suppression (23). This reduction can be attributed to the exposure and acceptance-based components of UTT, which systematically encouraged patients to tolerate distressing emotions and thoughts (20). By repeatedly experiencing internal discomfort without resorting to avoidance or compulsive strategies, participants learned that such distressing experiences are both temporary and

manageable (35). This experiential learning directly weakened the association between intrusive thoughts and compulsive responses (21).

Furthermore, UTT enhanced psychological flexibility, enabling patients to respond adaptively to internal experiences while continuing to pursue meaningful, value-driven activities (27). The decreased reliance on avoidance strategies corresponded with a reduction in compulsive behaviors and improved functional outcomes, underscoring that targeting experiential avoidance is a critical mechanism for reducing OCD symptom severity.

Analysis of post-treatment data also indicated a significant decrease in cognitive fusion among participants. Prior to the intervention, many patients treated intrusive thoughts as literal threats, leading to excessive attempts to neutralize or control them through compulsions. Following UTT, participants demonstrated a clearer capacity to observe thoughts as mere mental events, effectively decoupling their obsessions from perceived reality (28). This cognitive shift significantly diminished the compulsive responses triggered by intrusive thoughts. The observed improvement can be explained by UTT's emphasis on cognitive defusion techniques, including mindfulness exercises and thought-labeling strategies (35). These practices aided patients in recognizing that thoughts do not dictate actions and are not inherently dangerous (29). By altering the manner in which patients relate to their internal experiences, UTT disrupted the maladaptive thought-behavior patterns that typically perpetuate OCD (27). Additionally, the therapy enhanced metacognitive awareness, allowing participants to monitor and respond to obsessive thoughts with reduced automatic reactivity (22). The reduction in cognitive

fusion contributed not only to decreases in anxiety and compulsions but also to improved emotional regulation and overall psychological resilience, highlighting the central role of cognitive fusion as a therapeutic target in OCD treatment.

The results further revealed a significant reduction in self-conscious emotions, including shame, guilt, and embarrassment, following the intervention. Prior to therapy, participants often experienced intense moral distress in response to intrusive thoughts, which exacerbated anxiety and propelled compulsive behaviors (29). Post-treatment data indicated that patients reported a lower intensity of these emotions, reflecting an increased capacity to tolerate intrusive thoughts without harsh self-judgment (20). This change is likely attributable to UTT's focus on normalizing intrusive thoughts and promoting self-compassion (26). By assisting patients in understanding that experiencing unwanted or disturbing thoughts does not equate to moral failure or personal defect, the therapy reduced maladaptive self-evaluation and diminished the emotional burden of obsessions (21). Moreover, the intervention fostered improved emotional regulation and awareness, enabling participants to experience self-conscious emotions without defaulting to compulsions (35). As patients gained greater insight into the transient and non-threatening nature of these emotions, overall symptom severity decreased, illustrating that addressing self-conscious emotions constitutes a key pathway through which UTT improves outcomes in OCD.

One limitation of this study is the use of convenience sampling, which may affect the generalizability of the findings to broader and more diverse populations, as participants are selected based on ease of access. Despite this limitation, the results of this study indicate the effectiveness of UTT

in reducing key indicators such as experiential avoidance, cognitive fusion, and self-conscious emotions in patients with OCD. The findings suggest that clinicians can utilize UTT as a practical intervention to enhance emotional regulation and coping strategies in patients with OCD and other emotional disorders. Future studies are encouraged to explore the application of UTT in more diverse clinical settings. Additionally, examining the integration of this therapeutic approach with other existing treatment modalities could contribute to the development of more comprehensive interventions.

6. Conclusion

Despite this limitation, the results of this study substantiate the effectiveness of UTT in reducing key indicators such as experiential avoidance, cognitive fusion, and self-conscious emotions in patients with OCD. The findings suggest that clinicians can utilize UTT as a practical intervention to enhance emotional regulation and coping strategies in patients with OCD and other emotional disorders. Future studies are encouraged to explore the application of UTT across more diverse clinical settings. Additionally, examining the integration of this therapeutic approach with other existing treatment modalities could contribute to the development of more comprehensive and effective interventions. In summary, the present study provides evidence that UTT effectively modulates the fundamental cognitive and emotional processes that sustain OCD. By systematically targeting experiential avoidance, cognitive fusion, and self-conscious emotions, UTT facilitates a reorganization of the patient's relationship with internal experiences, shifting from rigid, avoidance-driven patterns toward greater psychological flexibility and adaptive self-regulation. These findings suggest that OCD symptomatology is not

merely a collection of discrete behaviors or intrusive thoughts but rather the emergent outcome of dynamic interactions among maladaptive cognitive appraisals, emotional dysregulation, and self-evaluative processes. Consequently, interventions operating at the level of these trans-diagnostic mechanisms can produce broad, durable changes extending beyond immediate symptom reduction, thereby enhancing resilience, emotional tolerance, and adaptive engagement with valued life domains. Overall, the results underscore the theoretical and clinical significance of addressing the processes underlying psychopathology rather than focusing solely on surface-level manifestations, positioning UTT as a robust framework for understanding and intervening in the complex architecture of OCD.

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