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Original Article

The Efficacy of Compassion-Focused Therapy on Imposter Phenomenon, Obsessive-Compulsive Disorder, and Alexithymia in Women with Sexual Dysfunction

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Abstract

Background: Sexual functioning refers to an individual's capacity to experience healthy and satisfying sexual responses across physical, psychological, and social domains. The present study focused on identifying the effectiveness of Compassion-Focused Therapy (CFT) on the reduction of the impersonator actions, Obsessive-Compulsive Disorder (OCD), and alexithymia in female adults with sexual dysfunction.

Methods: This was a quasi-experimental study with a pre-test/ post-test design involving a control group. The study sample included women with sexual dysfunction who were referred to healthcare centers in Ardabil Province, Iran, in 2024. Out of the list of patients, 36 women were chosen based on their medical history and the homogeneity of their medical condition. Then, the study participants were divided into the experimental group (n=18) and the control group (n=18). The balance between groups was provided based on the main clinical features. The experimental group attended eight 90-minute CFT sessions, and the control group did not receive intervention. The study participants were assessed using the Female Sexual Function Index (FSFI), Imposter Syndrome Scale (ISS), Obsessive-Compulsive Disorder Questionnaire (OCDQ), and Toronto Alexithymia Scale (TAS). The T-tests and ANCOVA analyses were performed in SPSS version 27.

Results: The results demonstrated that CFT significantly decreases the imposter phenomenon (CFT group: M=57.89, SD=4.05; control group: M=61.66, SD=2.84, P<0.001), OCD (CFT group: M=105.12, SD=5.45; control group: M=110.56, SD=4.86, P<0.001), difficulty of identifying feelings (CFT group: M=22.72, SD=2.69; control group: M=26.55, SD=1.88, P<0.001), difficulty of describing feelings (CFT group: M=24.06, SD=2.53; control group: M=27.76, SD=1.69, P<0.001), and externally oriented thinking (CFT group: M=19.66, SD=2.37; control group: M=22.43, SD=2.09, P<0.001) in women with sexual dysfunction.

Conclusion: The comparison of the two groups showed that the experimental group experienced greater improvements in these areas than the control group. By enhancing self-compassion and emotional regulation, CFT improves sexual and psychological well-being, with the potential for broader applications in future research.

Keywords: Compassion-Focused Therapy, Imposter Phenomenon, Obsessive-Compulsive Disorder, Alexithymia, Sexual Dysfunction

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1. Introduction

Sexual dysfunction in women is a complex and multifaceted condition that significantly impacts physical health, emotional well-being, and overall quality of life (1). Defined by persistent difficulties with sexual response, desire, orgasm, or pain during intercourse, sexual dysfunction affects millions of women globally, yet remains a largely underdiagnosed and underreported issue (2). The causes are often multifactorial, encompassing physical, psychological, and interpersonal factors, including hormonal imbalances, chronic illnesses, mental health disorders, and relational dynamics (3). Sexual dysfunction is seldom an independent matter since it is frequently combined with other mental issues like nervousness, malaise, and feelings (4). According to Gonçalves and colleagues (5), the rate of sexual dysfunction amongst patients with depressive disorder is very high, especially in patients who are not on pharmacological therapy. A previous meta-analysis and systematic review revealed that the total prevalence of major depressive disorder was 82.75% in women and 63.26% in

men, which had a significant impact on the sexual functions, both sexual desire (arousal and orgasm) and sexual satisfaction. Ashrafi and co-workers (6) found that female sexual dysfunction was prevalent in infertile women in Iran (98.8% in PCOS, 100% in endometriosis, and 80% in male factor infertility) against the background of fertile women (36.2%). This suggests the important relationship between infertility causes and sexual dysfunction.

Sexual dysfunction and psychological self-doubt are deeply intertwined, particularly for women experiencing the Imposter Phenomenon (IP), a pervasive fear of being inadequate or undeserving (7). This fear undermines self-worth in intimate relationships, fostering anxiety, reducing sexual confidence, and disrupting communication (8). Women with IP may avoid expressing their desires due to fear of judgment, leading to dissatisfaction, disconnection, and issues like low libido or pain during intercourse (9). The emotional stress associated with IP further amplifies physiological stress responses, exacerbating sexual health challenges (10).

Sexual dysfunction and obsessive-compulsive disorder (OCD) are closely interconnected, significantly affecting women's emotional and physical well-being (11). The intrusive thoughts and compulsive behaviors characteristic of OCD often extend into intimate relationships, fostering anxiety, shame, and preoccupation that create barriers to healthy sexual functioning (12). Obsessions about contamination, morality, or performance anxiety can diminish sexual desire, while compulsions like excessive cleaning or mental rituals leave little room for spontaneity (13). These challenges can lead to a cycle of distress, relational difficulties, and even avoidance of intimacy altogether (14).

Emotions are fundamental to intimacy and sexual well-being, shaping the way individuals connect with their desires and partners. Sexual dysfunction and alexithymia are closely linked, as difficulties in identifying and expressing emotions can create barriers to emotional and physical intimacy (15). Women with alexithymia often struggle to recognize their feelings, making it challenging to communicate effectively and foster deep emotional connections (16). This emotional disconnect can diminish arousal, satisfaction, and partner communication, leading to misunderstandings and relational strain (17). As a result, intimacy may feel mechanical rather than emotionally fulfilling, contributing to issues such as low libido, difficulty in achieving orgasm, and pain during intercourse (18).

Many medical treatments may not be effective on their own, as sexual dysfunction often requires psychological interventions. The efficacy of therapeutic approaches in addressing sexual dysfunction in women depends on their ability to target the psychological and emotional factors that underlie the condition (19). Sexual dysfunction is rarely a standalone issue, and frequently coexists with challenges such as anxiety, self-criticism, emotional disconnection, and relational difficulties (20). Therapeutic approaches focusing on these underlying issues, rather than just the physical symptoms, are more likely to yield meaningful and lasting improvements (21). Compassion-Focused Therapy (CFT) is particularly effective in addressing sexual dysfunction in women due to its emphasis on reducing self-criticism, fostering emotional awareness, and promoting self-acceptance (22). Many women with sexual dysfunction experience shame, guilt, or inadequacy surrounding their sexual lives, which perpetuates cycles of avoidance and dissatisfaction (23). CFT provides tools to cultivate self-compassion, helping women break free from these negative cycles and establish healthier emotional and relational patterns (24).

Studies suggested that interventions like CFT not only improve emotional well-being but also enhance sexual satisfaction and intimacy by reducing anxiety and fostering a sense of emotional safety (25, 26). By addressing the interplay between emotional regulation, self-perception, and intimacy, CFT provides a comprehensive approach that directly targets the core contributors to sexual dysfunction in women, making it a promising and effective treatment (22). Millard and colleagues (27) concluded that CFT effectively improves compassion-based outcomes (e.g., self-compassion, self-reassurance) and reduces clinical symptoms (e.g., depression, sexual dysfunction, and emotional disorders). Despite promising results, the study highlighted methodological limitations and emphasized the need for further research on CFT's long-term effects.

Sexual dysfunction in women is a complex condition often influenced by psychological factors such as IP, OCD, and alexithymia, all of

which contribute to emotional distress, self-doubt, and relational challenges. Despite the growing recognition of the psychological underpinnings of sexual dysfunction, limited research has focused on comprehensive therapeutic approaches that address these interrelated factors based on the literature search. CFT offers a promising intervention by targeting self-criticism, fostering emotional awareness, and promoting self-compassion, making it uniquely suited to address the core psychological barriers in women experiencing these conditions. This study aimed to evaluate the efficacy of CFT in improving psychological well-being and sexual functioning by addressing the interconnected issues of IP, OCD, and alexithymia, ultimately providing a foundation for more effective and holistic treatments for women with sexual dysfunction.

2. Methods

2.1. Design

This was a quasi-experimental study with a pre-test/ post-test design involving a control group.

2.2. Selection and Description of Participants

The sample included 75 patients who were referred to healthcare centers in Ardabil Province, Iran, in 2024. To detect women with sexual dysfunction, the Female Sexual Function Index (FSFI), designed by Isidori and colleagues (28), was applied as the main measure of sexual functioning. With 19 questions, FSFI assesses 6 main areas of sexual functioning, namely desire, arousal, lubrication, orgasm, satisfaction, and pain. It is a well-established tool for identifying sexual dysfunction in women across various research settings. Initially, the FSFI questionnaire was distributed to 75 women who had self-reported marital dissatisfaction. These women were selected based on preliminary interviews and psychological evaluations that assessed key factors contributing to relationship dissatisfaction. Given the known association between marital dissatisfaction and sexual dysfunction, these women were considered appropriate for inclusion in the study as an initial sample. Upon completion of the FSFI questionnaire, each woman's total score was calculated. Women who scored below 25 on FSFI, a commonly accepted cutoff in sexual dysfunction research, were classified as having sexual dysfunction. This threshold is widely used as it reflects clinically significant impairments in sexual function, as supported by the psychometric validation of FSFI. Those who met this criterion were subsequently included in the study. From the pool of women who met the sexual dysfunction criteria (FSFI score<25), 36 women were selected based on an evaluation of their medical history and the homogeneity of their condition. The selection process ensured that the participants were comparable across key variables, enhancing the validity of the study findings.

2.3. Sample Size Determination

The participants were selected from a comprehensive registry of eligible patients based on predefined inclusion and exclusion criteria. After eligibility confirmation, 36 participants were randomly assigned to either the experimental group (n=18) or the control group (n=18) using a computer-generated simple randomization process. This approach ensured allocation concealment, minimized selection bias, and maintained equivalence in key demographic and clinical characteristics between the two groups. To determine the sample size, the average and standard deviation of FSFI scores of other studies were taken as reference values. Recent studies (4-5) reported that the mean FSFI score in the control group was 28 (SD=4), while the experimental group had a mean score of 22 (SD=5). These values were entered into G*Power 3.1 to calculate the required sample size. An alpha level (α) of 0.05 and a desired statistical power ($1-\beta$) of 0.97 were specified, commonly adopted to minimize the likelihood of Type II errors. Based on these parameters, the calculation indicated that a total sample of 36 women (18 per group) would provide sufficient statistical power to detect significant differences between the experimental and control groups (29). The inclusion criteria were: willingness to participate, an FSFI score below 25, age between 20 and 35 years, and the absence of musculoskeletal problems. Participants were excluded if they missed more than two sessions, failed to complete the questionnaires, or exhibited behaviors that could exacerbate marital issues. Ethical considerations were fully observed, including obtaining informed consent, protecting personal data, and ensuring voluntary participation, in accordance with the general principles of the Helsinki Declaration.

2.4. Data Collection and Measurements

2.4.1. Female Sexual Function Index (FSFI)

Isidori and colleagues (28) developed a short form of the Female Sexual Function Index (FSFI). This questionnaire assesses women's sexual function and problems across six domains over the past four weeks: sexual desire, sexual arousal, lubrication, orgasm, individual satisfaction, and pain during intercourse. Items related to sexual desire and satisfaction are scored using a five-point Likert scale ranging from 1 to 5. The items tapping on the theme of lubrication, arousal, orgasm, and pain have a six-point Likert scale of 0 to 5. The score of the entire scale is obtained by summing up the scores obtained in the six sub-scales. The maximum score is 30 and the minimum score is 2; the higher the score, the better the sexual functioning. It was established that the proper cut-off score of the entire scale in the diagnosis of sexual dysfunction is 28. The reliability-retest of 0.95 and internal consistency of 0.78 were found in the research carried out by Isidori and colleagues (28) regarding this index. In another study, Shehnifayz and co-workers (30) found the convergent and divergent validity between the scale of women's sexual function and the scale of sexual distress and desirable positive affect (0.87). The Content Validity Index (CVI) and Content Validity Ratio (CVR) for the questionnaire in the present study were calculated to be 0.85 and 0.86, respectively, which have been deemed adequate to provide adequate content validity. Cronbach's alpha, as a measure to examine internal consistency reliability, turned out to be 0.84.

2.4.2. Imposter Syndrome Scale (ISS)

Clance and Imes (31) were the first to develop the Impostor Phenomenon Scale, which consists of 20 items. Participants rate their agreement with each statement using a five-point Likert scale, ranging from "never" to "very much." Total scores below 40 indicate a low level of impostor feelings, scores between 41 and 60 indicate a moderate level, scores between 61 and 80 indicate a high or pathological level, and scores above 80 indicate severe impostor tendencies. Clance and Imes reported high internal consistency, with Cronbach's alpha ranging from 0.85 to 0.94 (31). In the Iranian population, Bagheri Sheykhangafshe and colleagues (32) reported a Cronbach's alpha of 0.83, a Spearman-Brown coefficient of 0.73, and a Guttman split-half coefficient of 0.73. In the present study, the CVI and CVR were 0.81 and 0.84, respectively, indicating acceptable content validity. The scale also demonstrated satisfactory internal consistency, with a Cronbach's alpha of 0.82.

2.4.3. Obsessive-Compulsive Disorder Questionnaire (OCDQ)

Sanavio (33) developed the Padua Inventory in Italy, a 60-item self-report questionnaire designed to assess both clinical and non-clinical populations and to evaluate the severity of OCD symptoms. The inventory distinguishes between obsessive thoughts and compulsive behaviors (33). The Padua Inventory was first standardized for the Iranian population. Regarding convergent validity, the total scores of the Padua Inventory showed correlations of 0.65–0.75 with the Maudsley Obsessive-Compulsive Inventory and the Leyton Obsessive Inventory. The reliability of the instrument in the Iranian population was confirmed, with a test-retest reliability of 0.84 and Cronbach's alpha of 0.95 (34). Furthermore, the CVI and CVR were 0.89 and 0.82, respectively. Overall, the Cronbach's alpha coefficient of 0.89 indicated strong internal consistency and reliability.

2.4.4. Toronto Alexithymia Scale (TAS-20)

The 20-item alexithymia scales formulated by Bagby and colleagues (35) comprise three subscales that are the difficulty of feeling identification, the difficulty of feeling description, and externally oriented thinking. The answers are evaluated on the scale of five-point Likert scale (completely disagree/completely agree) with marks between 20-100. Bagby and colleagues (35) found the reliability of the score to be 0.81 with a Cronbach's alpha of 0.77. The Cronbach's alpha of the score in Iran was between 0.71 and 0.83, while its test-retest ranged between 0.61 and 0.69 (36). In this study, CVI and CVR of the questionnaire were 0.84 and 0.89, respectively, with satisfactory content validity. Moreover, Cronbach's alpha coefficients related to the subscales were 0.83, 0.85, and 0.87, indicating acceptable internal consistency.

2.4.5. Compassion-Focused Therapy (CFT)

Gilbert (37) first introduced a theory centered on self-compassion and integrated this concept into

therapeutic practice. This model was developed in response to the limitations of cognitive-behavioral therapies in addressing persistent negative emotions. CFT emphasizes teaching key components such as empathy, compassion for oneself and others, acceptance, tolerance of challenges, responsibility, and a sense of self-worth. For the pre-assessment phase, the study was conducted at a sexual dysfunction treatment clinic. A voluntary and convenience sampling method was employed, resulting in the recruitment of 36 women diagnosed with sexual dysfunction. To receive the responses, the study participants were directly contacted. The intervention group with a population of 18 people received eight 90-minute group therapy sessions. In the meantime, the control group received no training, being left on a waiting list. A group engagement by a psychologist was done at the intervention sessions, but with adherence to health practices. The sessions took place on Saturdays and Tuesdays at one of the centers of psychological service delivery, and there were no dropouts in both the intervention group and the control group. After the intervention, both groups filled in the post-treatment questionnaires. Table 1 summarizes in detail a description of the intervention sessions based on the manual developed by Gilbert (37) on the use of CFT.

2.5. Procedure

After obtaining the required research permits, the researcher conducted a random selection process among the patients referred to healthcare centers in Ardabil Province, Iran. Women who scored below 25 on FSFI were identified as the final study sample. Based on the objectives of the study and patients' symptoms, 36 women diagnosed with sexual dysfunction were randomly selected. Following the sampling process, the study participants were randomly assigned to either the experimental (n=18) or control (n=18) group using a lottery method (Figure 1).

2.6. Data Analysis

Data analysis was performed using SPSS version 27. Mean and standard deviation were computed as descriptive statistics of the sample characteristics. To determine the normality of data, the Shapiro-Wilk test was used, while the homogeneity of variance was determined through the application of the Levene test. In the case of inferential statistics, the Chi-square tests were applied to compare the

Table 1: Summary of Compassion-Focused Therapy sessions

Session	Target	Topic
1	Introducing and Establishing the Therapeutic Relationship	Conducting the pre-test, explaining the research variables, discussing the purpose, role, and significance of the sessions, clarifying the structure of the meetings, and introducing the general principles of compassion-focused therapy.
2	Developing Compassionate Understanding and Addressing Shame	Learning about brain systems underlying self-compassion, introducing the three-circle model of emotion regulation, presenting the philosophical foundations of compassion-focused therapy (evolved mind, threat mind, and social mind), introducing the evolutionary functional model of emotions, training metaphors (diarrhea and vomiting), teaching the garden metaphor, practicing soothing rhythm breathing, and assigning homework for the next session.
3	Teaching the Foundations of Self-Compassion	Presenting the core components of self-compassion, including self-kindness, common humanity, and mindful awareness, and introducing compassionate qualities such as strength, courage, wisdom, gentleness, and non-judgment.
4	Transforming the Understanding into Compassionate Awareness through Practice	Training the brain through mindfulness practices, developing a non-judgmental and accepting stance toward thoughts, feelings, and behaviors, practicing breath-focused attention, introducing informal mindfulness exercises, teaching formal mindfulness practices, and assigning homework for the following session.
5	Conceptualizing Shame and Self-Criticism	Practicing compassionate responses by learning how to treat oneself as a friend, identifying common forms of self-criticism, introducing the sleeping tiger metaphor, developing a compassionate self-identity, and assigning tasks for the next session.
6	Practicing Compassionate and Self-Compassionate Imagery	Providing examples of experiential learning, practicing self-compassion imagery, creating a safe place exercise, and assigning homework for the next session.
7	Practicing Writing of Compassionate Letters to Oneself	Demonstrating unconditional self-acceptance practices, applying these methods in real-life relationships with relatives, children, friends, and acquaintances, and assigning homework for the following session.
8	Reviewing and Rehearsing Previously Learned Skills	Assisting participants in applying skills to various life situations, teaching strategies for maintaining and using compassion-focused techniques in daily life, concluding the intervention, and conducting post-tests.

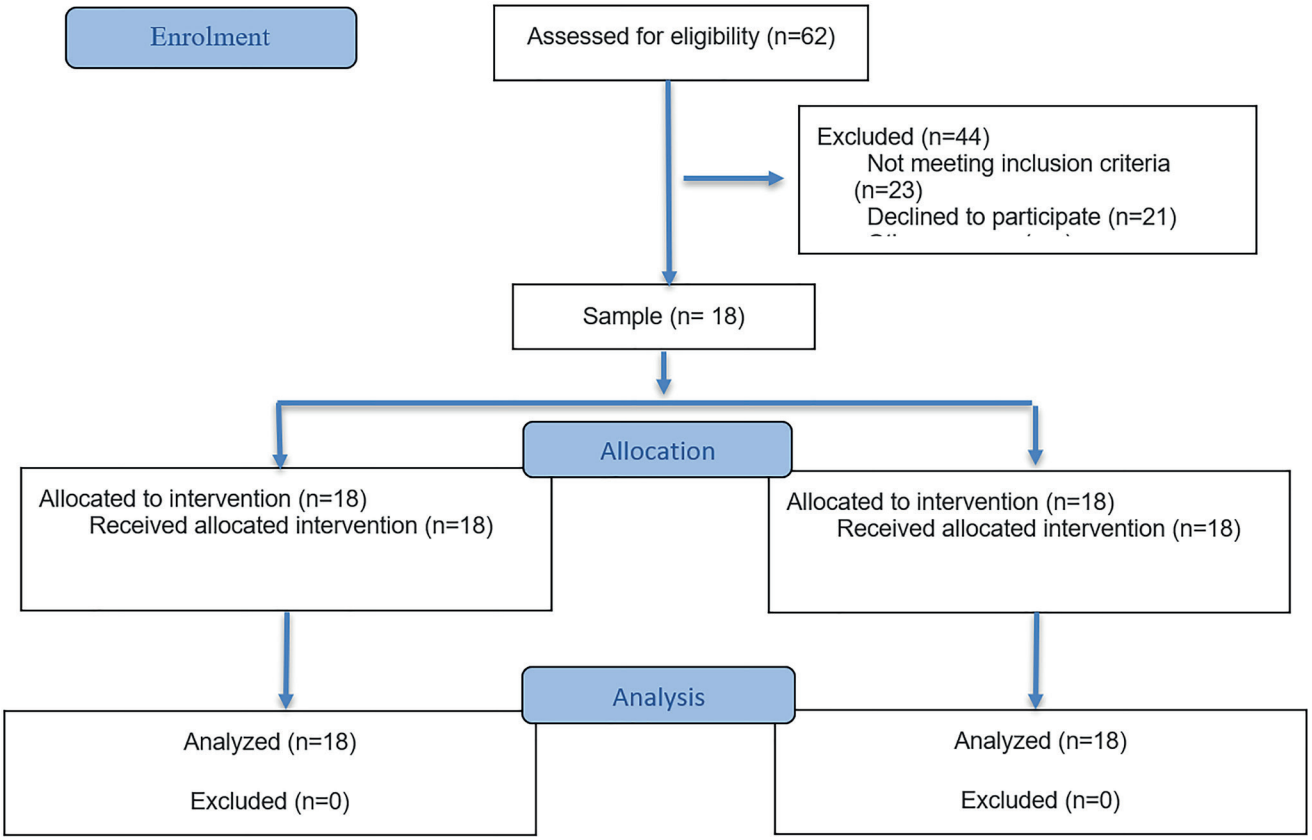

Figure 1: The figures shows the CONSORT flow diagram of the study.

demographic variables, and ANCOVA was used to investigate the impact of CFT on the dependent variables (IP, OCD, and alexithymia) with the impacts of potential confounding variables. Also, the paired t-tests were conducted to assess the mean differences between the pre- and post-test scores in each group.

3. Results

The participants were the patients who were referred to healthcare centers in Ardabil Province, Iran, in 2024. The mean age was 31.02 years (SD=8.16) in the experimental group and 30.79 years (SD=7.35) in the control group, respectively.

Table 2 shows that there was no statistical significance between the two groups in terms of the demographic characteristics. A chi-square test was used to compare age, duration of sexual dysfunction, and the level of education between the experimental group and the control group. The findings showed that there were no significant variations in the groups (P>0.05).

Table 3 shows the mean and standard deviation of the pre-test and post-test scores for IP, OCD, and alexithymia in women with sexual dysfunction in the experimental and control groups. Table 3 indicates that there is no significant difference in the pre-test between the two experimental and control groups.

The outcome of the Levin test carried out to test the homogeneity of variance of dependent variables within groups revealed that the variances of IP, OCD, and alexithymia were homogeneous in the groups (P>0.005). The Box M test outcome to test equality between the covariance matrices of dependent variables between the experimental and the control group showed that the covariance matrix of the dependent variables is the same (Box M=15.06, F=0.844, P>0.629). The Box's M test was not significant (P> 0.05), indicating that the assumption of equality of covariance matrices was met.

The homogeneity of regression coefficients was tested by means of interaction (dependent and independent variables) in the pre-test and post-test via the intervention method. There is evidence that the interaction of these pre-tests and post-tests with the independent variable was not significant, showing that the slope of the regression was homogeneous.

Table 2: Demographical characteristics of participants in experimental and control groups

	Experimental Group		Control Group		Chi-square
Age	**Frequency**	**Percentage**	**Frequency**	**Percentage**	**(P value)**
20 to 27	7	38.9	8	44.4	0.091
28 to 35	11	61.1	10	55.6	
Duration of Sexual Dysfunction	**Frequency**	**Percentage**	**Frequency**	**Percentage**	
1 to 2 years	10	55.6	9	50.0	0.053
More than 3 years	8	44.4	9	50.0	
Education Level	**Frequency**	**Percentage**	**Frequency**	**Percentage**	
Diploma	4	22.2	5	27.8	0.064
Bachelor	9	50.0	10	55.6	
Master	5	27.8	3	16.6	

Table 3: Descriptive indices of the variables in the experimental and control groups

Variables	Group	Pretest	Posttest	P¥
Sexual Function	Intervention	17.10±3.27	21.35±3.05	0.001
	Control	17.29±3.40	17.81±3.11	0.562
	P£	0.409	0.001	
Imposter Phenomenon	Intervention	61.62±2.93	57.89±4.05	0.001
	Control	61.55±2.95	61.66±2.84	0.955
	P£	0.861	0.001	
Obsessive Compulsive Disorder	Intervention	110.44±4.99	105.12±5.45	0.001
	Control	110.30±4.83	110.56±4.86	0.946
	P£	0.755	0.001	
Difficulty Identifying Feelings	Intervention	26.43±2.03	22.72±2.69	0.001
	Control	26.31±2.05	26.55±1.88	0.872
	P£	0.811	0.001	
Difficulty Describing Feelings	Intervention	27.65±1.81	24.06±2.53	0.001
	Control	27.55±1.78	27.76±1.69	0.854
	P£	0.809	0.001	
Externally Oriented Thinking	Intervention	22.56±2.12	19.66±2.37	0.001
	Control	22.64±2.02	22.43±2.09	0.873
	P£	0.841	0.001	

The values are presented as a mean SD, the P¥ was the result of comparing within a group and the P£ was reported as a between-group comparison.

Table 4: Adjusted marginal means of psychological variables in intervention and control groups

Dependent Variable	Group	Marginal Mean	95% CI	F	P	Eta Square
Imposter Phenomenon	Intervention	57.86	57.10-58.62	52.36	<0.001	0.64
	Control	61.68	60.92-62.45			
Obsessive Compulsive Disorder	Intervention	105.03	103.90-106.17	50.51	<0.001	0.63
	Control	110.63	109.49-111.76			
Difficulty Identifying Feelings	Intervention	22.67	21.91-23.44	54.26	<0.001	0.65
	Control	26.59	25.83-27.36			
Difficulty Describing Feelings	Intervention	24.02	23.34-24.70	64.10	<0.001	0.69
	Control	27.80	27.12-28.49			
Externally Oriented Thinking	Intervention	19.70	19.10-20.31	41.69	<0.001	0.59
	Control	22.40	21.80-23.01			

CI: Confidence Interval

Thus, the multivariate analysis of covariance assumptions was fulfilled. Table 4 shows the results of the multivariate analysis of covariance in comparing the two groups. The adjusted marginal post-test score, which includes baseline covariates, displayed that difference between two groups prior to covariate adjustment was significant about IP (F=52.36), OCD (F=50.51), difficulty of identifying feelings (F=54.26), difficulty of describing feelings (F=64.10), and externally oriented thinking

(F=41.69) at the level of 0.001.

4. Discussion

The present study aimed to determine the efficacy of CFT in addressing IP, OCD, and alexithymia in women with sexual dysfunction. The study findings demonstrated that CFT significantly reduces IP in women with sexual dysfunction. By cultivating self-compassion and addressing patterns of self-criticism, CFT helps women overcome feelings of inadequacy and fear of being perceived as "fraudulent." This change fosters a stronger sense of self-worth, empowering women to navigate their relationships and personal challenges with greater confidence (27).

The significant reduction in IP observed in women with sexual dysfunction following CFT can be attributed to the therapy's emphasis on self-compassion and its ability to disrupt the self-critical thought patterns central to IP (22). Women experiencing sexual dysfunction often internalize their challenges as personal inadequacies, which exacerbates the feelings of fraudulence and fear of judgment in intimate relationships (37). CFT works by fostering a compassionate mindset toward oneself, encouraging women to replace self-criticism with kindness and understanding (19). This shift allows them to reframe their perceived shortcomings as part of a shared human experience, reducing the shame and self-doubt that feed into IP (25). Additionally, CFT enhances emotional regulation and the ability to respond constructively to negative emotions, which further helps diminish IP. Through exercises such as mindfulness and compassionate imagery, CFT equips women with tools to manage anxiety and insecurity associated with IP (26). By creating a sense of emotional safety and acceptance, women are empowered to challenge and reinterpret the rigid beliefs that contribute to their feelings of inadequacy (8). Over time, this practice not only reduces the cognitive and emotional burden of IP but also enables women to approach their intimate relationships with greater confidence and authenticity, leading to improved emotional and relational well-being (20).

The study revealed that CFT effectively alleviates OCD in women. Through emotional regulation techniques and fostering a sense of safety, CFT reduces the frequency and severity of intrusive thoughts and compulsive behaviors. These improvements enable women to experience lower anxiety and greater emotional stability, creating a more conducive environment for intimacy and well-being (23).

OCD is characterized by intrusive thoughts and repetitive compulsions, which often intensify anxiety and disrupt emotional well-being (21). For women with sexual dysfunction, these symptoms create additional barriers to intimacy by amplifying emotional distress and fostering avoidance behaviors (12). CFT effectively addresses these issues by targeting the underlying emotional dysregulation that fuels OCD (37). By promoting self-compassion and activating the soothing system of the brain, CFT helps diminish the dominance of threat-based responses that drive obsessive and compulsive tendencies (20). This shift reduces the power of intrusive thoughts, enabling women to disengage from compulsive cycles and experience a greater sense of emotional safety (26). Furthermore, CFT introduces women to techniques such as compassionate imagery and mindfulness, which allow them to process intrusive thoughts without judgment or fear (21). These practices help reframe the intrusive content as less threatening, disrupting the feedback loop of compulsions (37). The therapy's emphasis on emotional regulation creates a balanced environment in which women can better manage anxiety and reduce the emotional intensity that typically accompanies OCD (22). Over time, these changes promote psychological resilience, allowing women to engage more fully in their intimate relationships and break free from the patterns of avoidance and disconnection that OCD often perpetuates (25).

The results also showed that CFT contributes to a significant reduction in alexithymia among women with sexual dysfunction. By enhancing emotional awareness and self-compassion, CFT helps women better recognize, understand, and express their emotions. This improvement strengthens emotional communication in relationships, deepens intimacy, and positively impacts overall mental health (26).

In explaining the obtained results, it can be argued that CFT effectively reduces alexithymia (difficulty of identifying feelings, difficulty of describing feelings, and externally oriented thinking) in women with sexual dysfunction by addressing the core emotional and psychological

deficits underlying the condition (18). Alexithymia, characterized by difficulties in identifying, understanding, and expressing emotions, often disrupts emotional intimacy and relational satisfaction (37). For women experiencing sexual dysfunction, this emotional disconnect not only impairs self-awareness but also hinders effective communication with partners, reinforcing patterns of isolation and relational strain (24). CFT intervenes by fostering emotional awareness and promoting a compassionate relationship with oneself, equipping women with tools to identify, process, and articulate their emotions (22). This foundational improvement in emotional clarity lays the groundwork for healthier emotional engagement and deeper intimacy within relationships (19). What makes CFT particularly effective in reducing alexithymia is its focus on reframing emotional challenges through self-compassion, which acts as a buffer against emotional suppression and avoidance (27). Many women with alexithymia feel overwhelmed or inadequate when faced with emotional complexity, leading to further detachment and frustration (20). CFT encourages women to approach their emotional struggles with curiosity and non-judgment, transforming emotional difficulties into opportunities for growth and connection (24). This shift not only builds emotional confidence but also enhances the ability to express needs and feelings in intimate relationships (21). Over time, these improvements strengthen emotional resilience, foster a sense of emotional connection, and contribute to better mental health and relational well-being (26).

4.1. Limitations

There were some limitations in this study. The study was carried out only in Ardabil, Iran and only on women which restricts the outcomes to represent other people and other geographical zones. Also, this study was based on self-reports where self-report tools like FSFI could be prone to reporting bias, especially because of the sensitivity of the issue at hand. Another considerable limitation concerns the lack of the follow-up period which makes it impossible to establish the long-term impact and sustainability of the intervention. Moreover, socio economic status, educational level, and the cultural background, which can have an impact on the findings, were not fully studied. Those limitations indicated that future studies are to be conducted with an aim of increasing the sample size to another population, adding follow-up analysis to assess long-term changes and paying a more thorough attention to demographic and contextual backgrounds to form a more complex picture of the intervention efficacy.

5. Conclusions

The findings of this study underscored the profound potential of CFT in addressing the multifaceted psychological dimensions of sexual dysfunction in women. By fostering self-compassion, CFT dismantles the cycles of self-criticism, emotional avoidance, and dysregulation that underpin conditions such as IP, OCD, and alexithymia. The therapy's unique approach, which cultivates emotional resilience and a sense of safety, empowers women to confront internalized shame and reconnect with their emotional and relational selves. This transformation is achieved by replacing maladaptive thought patterns with a compassionate internal dialogue, allowing women to approach their challenges with greater confidence and acceptance. Ultimately, CFT demonstrates that addressing the psychological roots of sexual dysfunction, rather than solely focusing on physical symptoms, creates an integrative pathway toward emotional healing, relational satisfaction, and improved quality of life. Further exploration of this holistic framework could redefine therapeutic approaches for sexual dysfunction and related psychological comorbidities.

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Authors' Contribution

Farzaneh Habashi Varnosfaderani: Contributed to the conception and design of the study, supervised the research process; critically reviewed the manuscript for important intellectual content. Faezeh Moslemi: Contributed to data acquisition and analysis; drafting the manuscript. Vahid Savabi Niri: Contributed to data collection and interpretation; critically reviewed the manuscript for important intellectual content. Farzin Bagheri

Sheykhangafshe: Contributed to the study design; critically reviewed the manuscript for important intellectual content. Hojjatollah Farahani: Contributed to the study design; critically reviewed the manuscript for important intellectual content. All authors have read and approved the final manuscript and agree to be accountable for all aspects of the work, ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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Ethical Approval

The study was approved by the Ethics Committee of Tehran Tarbiat Modares University, Tehran, Iran with the code of IR.MODARES.REC.1402.001. Also, written informed consent was obtained from all participants.

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