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Research Article

Comparison of the Effectiveness of Acceptance and Commitment Based Therapy and Cognitive Behavioral Therapy on the Quality of Life of the Women Withdrawing the Crystal (Methamphetamine)

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Abstract

Background and Objective: This research was conducted by comparing the effectiveness of the acceptance and commitment based therapy and cognitive behavioral therapy on the quality of life of the women who are withdrawing the crystal.

Methods: The research method has been semi-experimental of pretest, posttest type with the control group, and the implementation of acceptance and commitment therapy method and cognitive behavioral therapy has been on two experimental groups with a three-month follow-up stage. The statistical population of this research was composed of all women who were withdrawing, referred to the withdrawing addiction therapy centers during the time period of September 2016 to March 2017 in Isfahan province and after exclusion of 13 people in the group under acceptance and commitment therapy, and 10 people in the group of cognitive behavioral therapy and in the control group, 13 people remained as the sample in the research. The instruments used were the Acceptance and Commitment-Based Therapy Protocol in Addiction by Hayes et al. (2004), and Hayes et al. (2004), as 15 sessions of 90 minutes, and the Cognitive Behavioral Therapy Protocol in Addiction by Carroll (1998) and the questionnaire of the quality of life of Frisch (1994). Repeated measures ANOVA was also used.

Results: The findings based on the mean indicator in the pretest, posttest and follow-up of therapeutic effects in the quality of life component indicate that the acceptance and commitment based therapy is more effective that the cognitive behavioral therapy in improving the quality of life of women who are withdrawing crystal.

Conclusion: Therefore, it is suggested that the researchers use the acceptance and commitment based therapy and behavioral cognitive therapy, the two protocols used in this research in other populations and the consumers of drugs, and the applied implications to improve the psychological status and the promotion of the quality of life of women who are withdrawing can be presented to the therapists.

Keywords: Acceptance and Commitment Based Therapy, Quality of Life, Cognitive Behavioral Therapy, Women Withdrawing Crystal

Background and Objective

Addiction has been one of the greatest problems and tragedies of human society since the past ages[1]. Addictive substances can be categorized in many ways and they are classified as natural, semi-synthetic and synthetic, but the World Health Organization has divided addictive substances into six general categories for their effects on humans: Hallucinogens, cannabis or hemp syrup, opiate addicts, laxatives, sedatives, adhesives and volatiles (inhalants), stimulants (such as amphetamine) and alcohol. On the other hand[2]. Methamphetamine addictives, which are chemicals, are of the methamphetamine category as stimulants that increase the activity of the nervous system[3]. Consuming the usual amount of stimulants can cause high energy and excessive consumption can cause severe discomfort and restlessness, and in others, it can be associated with euphoria and ultimately continued depression[4]. Research suggests that the use of addictive substances such as methamphetamine (glass) with poor mental health[5].

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Bernstein et al. (2003) is associated with impulsive and risky behaviors, satisfaction and quality of life, and addiction and craving tendencies[6] . On the other hand, in the field of physical issues different research on the relationship between methamphetamine (glass) consumption and the methamphetamine group with high-risk sexual behaviors and indicate the risk of various diseases including STI[7]. In this respect, it seems logical that a person who has psychological and physical problems will have different levels of quality of life[8]. Quality of life has a subjective meaning, and each person's perception of life is presented as a multidimensional concept such as positive psychology and mental wellbeing, based on one's perception and understanding of one's life situation in relation to cultural factors, goals, beliefs and beliefs that may be important factors. It must be a genre, designated[9]. Most scholars agree that quality of life considers the positive and negative facts of life together and that the concept is always physical, psychological, social, psychological, and symptoms related to the absence of illness (Naeem, Picard, Ayoub, and others). Basically, quality of life is strongly correlated with physical, psychological, personal beliefs, self-esteem, social relationships, and the environment[10]. In general, researchers such as focus on three characteristics: 1. Multidimensionality including physical, psycho-emotional, social, spiritual, illness symptoms, 2. subjectivity, and 3 . Being dynamic, they agree. Consumers are also likely to experience a change in quality of life due to differences in meeting basic human needs and priorities, reflecting one's expectations and perceptions that reflect the quality of real life[11]. States that perceptions of quality of life affect self-esteem, general status and support, and on the other hand, it seems that quality of life includes two dimensions of mental and physical functioning, both of which are due to negative psychological consequences (depression, anxiety). And the breakdown of family relationships and physical (physical pain and weakness) addiction are associated with substance use[12]. Some studies in limited female populations, especially in large cities, show that current patterns of addiction are changing and new manifestations of drug dependence are emerging and emerging[13]. The increasing trend of addiction with such a steep slope necessitates special attention to the issue of women's addiction, and it is necessary to identify the gender differences affecting drug addiction and preventive interventions tailored to feminine gender based on cultural and social design features[14]. This is especially important when women are less resistant than men to addictive substance abuse, and their duration of addiction and dependence is much shorter than first use. At the same time, due to gender characteristics such as physical problems or the support of spouses and families, treatment is much more difficult[15]. Methamphetamine (such as glass) addiction is associated with physical problems, poverty, violence, criminal behavior and social exclusion for women, and it is difficult to estimate all its costs to society[16], including reduced ability to generate income and family income, violence, security problems, road accidents. And AIDS and financial corruption are linked to hepatitis[17]. To date, no specific drug has been approved for the treatment of dependence on stimulants such as glass and the basis of treatment for this disorder is psychological interventions. The use of psychological therapies today has a special place in the treatment processes of addicts[18].

One of the therapeutic methods used in psychology to control and treat this disorder is cognitive-behavioral techniques[19]. The fundamental assumption of cognitive-behavioral therapy is that learning processes play an important role. And persist with drug addiction and drug dependence, and in simpler terms, cognitive-behavioral therapy helps identify, avoid, and confront patients[20]. That is, identifying situations in which the probability of substance use is high and allowing them to be avoided and effectively tackled[21]. On the

other hand, the research background and the results that therapists have gained from this therapy have led them to always seek to improve this therapy in the third wave of modification and incorporation of the cognitive-behavioral approach to the principles[22]. The underlying responsibilities and perceptions of reality have become more solid, which have emerged with a greater emphasis on cognitive aspects. Acceptance and Commitment Therapy Emphasizes beliefs, schemas, and information processing systems in the creation of psychological problems[23]. In the field of addiction, it focuses on cognitive beliefs, spontaneous beliefs and thoughts that are involved in drug elasticity, while behavioral techniques focus on actions that are contextually interacting with cognitio[24]. The main goal of treatment is acceptance and commitment to create mental flexibility[25]. In the acceptance and commitment approach, unlike cognitive-behavioral therapy, the content of thoughts, feelings, and physical senses is not examined[26], but rather the ways in which people use their experiences[27]. In fact, an acceptance and commitment approach does not force individuals to modify their thoughts and feelings, but rather to help them change their own responses to their thoughts and feelings[28]. Research shows that acceptance and commitment-based therapy works better and more effectively than cognitive-behavioral therapy in maintaining drug use abstinence rates, reducing addictive substance use and improving quality of life[29]. There are also some studies on the impact of cognitive-behavioral therapy on different levels of cognitive issues and the positive effects on quality of life experienced in the treatment of addictive substance use[30]. There are also some studies on the impact of acceptance and commitment based treatment on quality of life in the treatment of addictive substance use. Since the first step to improve healthy relationships with the environment in early prevention is early education programs and considering the role and effectiveness of cognitive-behavioral training and acceptance-based therapy and commitment on many psychosocial variables of substance abusers Addiction has been reported in numerous studies, including Graham et al. (2016) and Hayes et al. (2004), and now the question arises as to whether there is a link between the effectiveness of acceptance and commitment therapy. And Cognitive-Behavioral Therapy Therapy on the Quality of Life in Smoking Women has it?[31,32]. (Table 1).

Table 1. Reliability of the quality of life questionnaire by different researchers

Amount Alpha	Components	Alpha
Clark, Ross, Rhode, Pavlik and Greenstone (2005)	quality of life	0.73
Padash (2012)	quality of life	0.83

Methods

The statistical population of this research was composed of all women who were withdrawing, referred to the withdrawing addiction therapy centers during the time period of September 2016 to March 2017 in Isfahan province and after exclusion of 13 people in the group under acceptance and commitment therapy, and 10 people in the group of cognitive behavioral therapy and in the control group, 13 people remained as the sample in the research. Sample and two-stage sampling method Initially, 80 non-randomly selected women who were referred to all 18 drug addiction rehabilitation and rehabilitation centers covered by Isfahan Welfare Organization were selected using non-random sampling method. Entering and exiting 45 individuals were randomly selected and assigned to groups randomly in one experimental group (15 in Acceptance and Commitment group and 15 in Cognitive Behavioral Therapy (and 15 control group).

Quality of Life Questionnaire: The Quality of

Life Questionnaire was developed for both clinical and non-clinical use. Its use in non-clinical and positive psychology-based cases is a criterion for assessing quality of life and life satisfaction based on coherent theories that guide therapeutic interventions and are indicators of the reliability and validity of therapeutic efficacy[33]. Its use in clinical cases is a criterion for positive or life satisfaction mental health based on coherent theories that improve the tools and indicators available for negative emotions and symptoms of mental illness or disorder and are useful in the following cases: Clinical screening / health Mental. Evaluation of Mental Health Progress and Outcomes and General / Behavioral Medicine Programs and Treatments. Treatment Plans in Mental Health and General Medicine / Behavioral Medicine. The Quality of Life Questionnaire is also just one of the tools available to assess life problems and is an essential part of cognitive therapy and cognitive conceptualization. The Quality of Life Questionnaire is a measure of satisfaction based on domains of life that seeks to overcome situational biases that only measure overall life satisfaction and exposes subjects to important and unimportant aspects of life. It is based on important areas of life[34]. This questionnaire consists of 10 parts and each part has 2 questions. The first question has three options (zero point is not important for me; 1 point is important; 2 is very important for me) and the second question has six options (very dissatisfied Zero Dissatisfied Score 1 Somewhat Dissatisfied Score 2 ؛ Neither satisfied nor dissatisfied Score 3 ؛ Somewhat Satisfied Score 4 Satisfied and Very Satisfied Score 5). This questionnaire has a total score. Higher scores indicate better desirability of quality of life[35].

Validity and Reliability: Leslie et al. (2005) obtained reliability and temporal stability of the Quality of Life Questionnaire scores based on test-retest reliability coefficients in subgroups consisting of 55 subjects in the normative study. Test-retest reliability coefficient at two weeks interval was 0.73 and significant[36].

Cronbach's alpha coefficient of this questionnaire was 0.76 for the overall rating of life satisfaction. In addition, the findings of two other life satisfaction scales were collected to assess the convergent validity of the Quality of Life Questionnaire. This questionnaire showed a positive and significant correlation with both scales and the correlation with the Life Satisfaction Scale was 0.56 and the correlation with the Quality of Life Index was 0.75. The correlation between the T-scores in the Quality of Life Questionnaire and the Marlowe-Crand Social Rating Scale was 25%. Although this correlation was significant, because of its low level, it seems that the effect of social popularity on the quality of life questionnaire scores is low, as it only estimates 6% of the variance in the quality of life questionnaire scores[37]. In Iran, remuneration, Fatehizadeh and Losada et al. (2015) reported Cronbach's alpha coefficient of 0.86 and concurrent validity (r = 0.72). Also in the present study ، to evaluate the reliability of the questionnaire, after conducting a preliminary study and determining the variance of the questions, Cronbach's alpha coefficient was calculated and the total coefficient of the questionnaire was 0.88. The validity of the questionnaire was confirmed by its creators[38]. Simultaneously with gathering the principles in the library method and considering the field method to the research tools and according to the research method which is the effectiveness of group therapy (independent variable), so in order to collect the samples according to the available female referrals some people were initially selected. Two experimental groups (one control group) were randomly selected from the number of people who met the inclusion criteria and the therapeutic process was performed according to the 15-minute 90-minute acceptance and commitment therapeutic protocol on the first experimental group and the 15-session cognitive behavioral

therapy protocol. 90 minutes on the band The second trial was performed simultaneously during a maximum period of three months and a three-month follow-up period, which was conducted in late September 2016 to March 2016 in two separate separate groups during the week. During the treatment process, 2 patients in the first experimental group (Acceptance-based therapy) and 5 patients in the second experimental group (Cognitive-behavioral therapy) and 2 individuals in the control group (having personal problems, which exclude the criterion) were excluded from the study, it should be noted that the control group did not intervene, But control group sessions without psychotherapy (15 sessions, 90 d Colloquium on the dangers of addiction and the current status of current trends in Iranians, people's proposed challenges, perspectives, and personal history on how to recover and how often family status was co-ordinated with the experimental group and specifically from the three groups before Pre-test questionnaire tool was started at the beginning of the sessions and after the end of the test period, the dependent variable was measured for all three groups. Also, after a three-month post-test, a follow-up of the experimental and control groups was performed. In addition, after data collection, the raw data were analyzed and finally the assumptions and questions were analyzed and the results were compared. It should be noted that at the end of the study, after the follow-up phase, the control group was put on the waiting list.

1. The content of therapy sessions based on acceptance and commitment

Acceptance and Commitment Based Treatment Protocol for Addiction by et al. (2010) has been developed[39]. One session was performed per week (to practice the previous training session and to evaluate the experience of weekly assignments) and another 8 sessions per week (Table 2) and (Table 3).

Table 2. Summary of Acceptance and Commitment Therapy Sessions

Session One: Providing Preferences, What Referrals and Therapists Should Look For Avoiding Ineffective Methods
Session 2: Performance Assessment, Assignment Review, Creative Helplessness: Assess the techniques learned with the help of a therapist for mind control. Mindfulness exercises
Session 3, 4, and 5: Performance Assessment: The therapist examines any changes (internal and external motivators) in his or her environment such as frequency, severity or impairment of thought.
Sixth-seventh and eighth sessions: Review of response to previous session, Assignment review, Mindfulness / Acceptance Introductory Exercises, Behavioral Commitment Assessment, Assignment Presentation
Ninth / tenth / eleventh: teaching self-acceptance and self-expression of inner experiences, self-efficacy and self-reliance, self-observation instead of self-conceptualization, so that a person fails to interact with them and, along with the consciousness and acceptance of psychological flexibility, is created in person. Applying the metaphor of the wind And the cloud
Assigning values, measuring performance, reviewing previous session responses. Keywords: Mindfulness Exercises, Twelfth and Twentieth Centuries, Values Introduction, Behavioral Commitment
Performance Assessment, Review of Pre-session Reactions, Mindfulness Exercises 14 and 15: Introducing Self as Background and Fault, Introducing Value Assignment

Table 3. Summary of cognitive behavioral therapy sessions

Session	The strategies used
1	Individual Motivational Feedback. Deciding whether or not to continue using drugs Provide a table on the dangers of continued drug use and non-change.
2 and 3	The Benefits of Making a Change in Substance Use The Benefits of Continuing to Consume a Substance and No Change.
	The disadvantages of altering substance use. Determining High-Risk Situations and Drivers Emotions People Places Personal Design Objects Determining Negative Thinking Patterns
4 and 5	Planning to deal with the desire and desire to stop practicing substances.
	Coping with Negative Thinking Fighting Negative Thoughts and Reconstruction
6 and 7	Alerting one to high-risk situations Functional thinking analysis of risk taking. Using Flash Cards When Opposing Hierarchical Thoughts
8 and 9	Rejection and Coping Skills with Direct Suggestions for Consuming Material The design of refusal sheets plays a role in practicing criticism and being critical.
10 and 11	To be criticized and criticized. Anger Management and Substance Use Determining Signs and Symptoms of Critical Thinking Skills. A program of commitment to addressing the joyful events of alternative drug use

Results

Table 4. Mean and standard deviation of pre-test, post-test and depression follow-up, quality of life and craving for drugs

The dependent variable	Group	Pre-Test		Post-Test		Follow up	
		M	SD	M	SD	M	SD
quality of life	ACT	36.40	6.81	42.87	6.70	43.35	1.68
	CBT	35.73	4.99	41.13	4.69	40.87	3.85
	Control	36.13	8.42	36.60	7.78	36.01	6.97

As can be seen in (Table 4), the mean scores of pretest, quality of life in the experimental and control groups were approximately equal, but, in the post-test, the mean scores of the experimental groups in the acceptance and commitment therapy and cognitive behavioral therapy were higher than the mean in the control group.

Table 5. Follow-up values are also visible in the experimental and control groups.

Source of disin persian	sum of squares	Df	Main of squares	Analysis of variance	Sig
Stages of treatment	445.441	1	445.441	19.304	0.000
Group interaction * steps	757.547	1	757.547	32.103	0.000
Error	109.087	1	109.087		
groups	1286.143	2	643.071	27.276	0.00
Error	944.115	40	23.602		

The results (Table 5) indicate that there is a significant difference between the quality of life scores in the pre-test, post-test, pre-test with follow-up, and post-test with follow-up. Comparison of the adjusted averages showed that the scores in the posttest and the follow-up phase were significantly increased compared to the pre-test. There was also a significant difference between the quality of life scores in the posttest phase compared to the follow up phase, so that the quality of life scores in the follow up phase were significantly higher than the posttest stage.

Discussion

According to the results (Table 6), the interaction of stage factors and group calculated value for the effect of stages (pre-test, post-test and follow-up) between the two groups based on acceptance and commitment therapy and behavioral cognition therapy was significant at 5% level. The calculated F value for the effect of steps (pre-test, post-test and follow-up) was significant at the level of 0.05. (P = 0.942 = E0.05 / P <0.05, 19.4 = F). As a result, there is a significant difference between the mean scores of pre-test, post-test, and quality of life pursuit in the three groups. According to the results of (Table 2) for the three intergroup factors, there is a significant difference between the overall mean of quality of life in the two groups based on acceptance and adherence to cognitive behavioral therapy and control group. . In relation to the interaction of stage factors and group F calculated for the effect of pre-test, post-test and follow-up between the two groups based on Acceptance and Commitment Therapy and Cognitive Behavioral Therapy (P <0.05, 32.3 = 0.10). F), as a result, there was a significant difference between the mean scores of pre-test, post-test and quality of life pursuit in the two groups. According to the results (Table 5), for the intergroup factor, the calculated F value is significant at the level of 0.05. (Eta 2 = 883, P <0.05, F = 276/27). Bonferroni post hoc test results were calculated to examine the difference between the means in the three groups, which is visible in (Table 6). According to the analysis of the efficacy of two methods of acceptance and commitment based therapy and cognitive behavioral therapy on improving the quality of life of women leaving the methamphetamine (such as glass) showed a significant difference between the mean of post-test scores and the effect of acceptance and commitment based therapy and cognitive behavioral therapy. There was control over improving the quality of life of women leaving the methamphetamine.

Table 6. Summary of Bonferroni follow-up test results in experimental and control groups

levels	ST-Error	Main-Def	Sig
Pre-Post Test	2.463*	0.563	0.001
Pre - Follow up	1.886*	0.629	0.001
Post- Follow up	3.987	0.633	0.001

Therefore, it can be concluded that acceptance and commitment therapy and cognitive behavioral therapy have been effective in improving the quality of life of women in quitting. Also, comparing the efficacy of Acceptance and Commitment-Based Therapy with Cognitive-Behavioral Therapy, the results of post-test mean and follow-up showed a significant difference in the amount of effectiveness of Acceptance-Commitment and Cognitive-Behavioral Therapy, which is a measure of the mean of more efficacy based on Acceptance and Commitment Therapy. Women's lives are leaving the methamphetamine (specially glass). Therefore, it can be concluded that acceptance-based and commitment-based therapy to improve the quality of life of women leaving the methamphetamine is more effective than cognitive-behavioral therapy. These findings are in line with the findings of Tannery Research, McCallion & Zvolensky (2015), & Morriset al. (2018), Therapy based on its acceptability and cognitive behavioral therapy as an indirect mechanism[40,41]. Reducing behavioral and psychological problems can improve the quality of life and life satisfaction in individuals. It can be said that commitment and acceptance therapy decrease the level of acceptance and decrease intellectual inhibition by reducing the amount of stress in people with obsessive-compulsive disorder, which leads to physiological stress and pain and physical discomfort. Also, commitment and acceptance therapy, with special appeal to increase cognitive deficits and informed acceptance, will help these patients experience negative thinking in a new way and engage with and accept the thoughts they had previously avoided. Reduce avoidance of negative thoughts and attitudes and use their energy to move toward values rather than fighting negative thoughts and trying to control them which leads to improved quality of life for patients[42] . On the other hand, it seems reasonable that addicts at the time of referral for treatment are at least mentally challenged by the effectiveness of treatment and may not have a completely positive attitude toward the treatment process, so their resistance is initially observable but, if consciousness and cognition Complete treatment and feel changes at the beginning of treatment, will increase their confidence and they will be more willing and motivated to go through the treatment process and then if there is environmental support and encouragement. If so, therapeutic motivation will increase. This process occurs in cognitive behavioral therapies (with motivational interviewing).

In cognitive behavioral therapy, previous emotional experiences have always been linked to current experiences or their expressive terms; this makes individuals unable to relate to many of their experiences and to interpret and interpret them individually, without their own reason Avoid common issues; in acceptance and commitment therapy, this connection is considered one of the biggest barriers to treatment, and the therapist strives to eliminate this emotional attachment through various techniques[43]. The treatment process in the acceptance and commitment-based approach uses metaphors to examine one's ineffective methods and how to avoid ineffective control and control techniques so that the individual can reduce their cognitive integration and

connection and communicate better with their inner feelings. That identifies the personal values that have hitherto been disregarded, identifies the activities needed to achieve those goals, and targets the path formed along a sequence to enhance levels of satisfaction and Quality of life is about people.

Focuses on self-acceptance and self-directed therapies of change and reduction of symptoms for valuable living. The purpose of acceptance is to accept the whole person, feelings, memories of physical sensations without the need to defend against them[44]. Acceptance and commitment-based treatment through cognitive-fault interventions seek to help its clients become more resilient to their own mental capacities, and therefore more effective ways to interact directly with one another. This method introduces another kind of spontaneous self-name as the field (the transcendent ego). By this term, a sense of self is the context in which internal events such as thoughts, feelings, memories, and physical sensations occur, encouraging the observation and characterization of unrealistic experiences of present day experiences. As their minds make it out. Values are important areas of life for everyone, and they are used for personal disclosure to clients. Values referrals define the goals of their particular behaviors and identify potential barriers to achieving those goals. These barriers are usually psychological, and these things help to overcome them: acceptance, guilt, and communication. Also, authorities are encouraged that change reporting is committed[45]. And defining goals in specific areas that are valuable to the individual. Therefore, acceptance-based and commitment-based therapy balances shifting domains (such as overt behavior) with constant changes, focusing on acceptance and mindfulness. In conclusion, all interventions based on acceptance and commitment therapy (acceptance, faulting, self-context, living in the present, values of commitment) increase quality of life. The difference between these two treatment modalities in improving the quality of life can be said to be ineffective in acceptance and commitment by changing one's relationship with one's inner experiences of acceptance, self-awareness, and isolation from inward experiences, thereby indirectly altering the quality of life. Unlike cognitive behavioral therapies that directly address quality of life, identifying and modifying dysfunctional thoughts can change the perceptions and reinforce internal and external stimulus coping skills and develop in-person training, acceptance therapy, and commitment[46]. In this treatment, they are taught that any action to avoid or control unwanted mental experiences (sensations) is ineffective or reverses their effects and thereby eliminates inadequate feedback experiences. However, cognitive-behavioral therapy has also had a significant effect on improving the quality of life of women in quitting, and in the process of cognitive behavioral therapy sessions, women in quitting have been able to identify skills such as: identifying and defining the problem, how to deal with the problem, choosing the best. The solution is to maintain mental health and to acquire these skills. Women are not emotionally challenged by changing their cognitive and emotion management skills, addressing their own problems, with a well-reasoned perspective. His previous findings on drug use result from cognitive and chaotic analysis Relying on previous beliefs, he actually uses this method as a means to regain control of his sensory thoughts and learns how to challenge the tempting automatic thoughts associated with substance abuse by reminding himself how to challenge them. Don't get in the way of reuse and improve your quality of life by solving the problem and changing your lifestyle to improve your social and family relationships[47]. But the efficacy of acceptance therapy was more than cognitive behavioral therapy. Acceptance and commitment therapy focuses less on symptom reduction and more on enhancing quality of life, and clients want

to improve their quality of life, but they feel that they must first change the content of their thinking. Instead of focusing on changing and reducing signs, focus on creating valuable lives so that they are not resiliently surrendering their thoughts and laws, and instead find ways to interact more directly with the directly experienced world through self-transcendence. Now, it also strengthens the foundations of thought and general schemas in addition to correcting in the positive direction, and ultimately improving the durability of therapeutic effects in line with other methods such as Cognitive Behavioral Therapy, in both Acceptance and Commitment Therapy. Cognitive Behavioral Therapy Research Has tried to reinforce this positive attitude to treatment of addicted women was even less family support. Acceptance and commitment-based therapies have been more effective than cognitive-behavioral therapy. These findings can provide great hope for addicts and counselors in addicts because therapists use cognitive-behavioral therapy strategies to improve quality. The life of cracked women shows that addicts can continue to be the best and most rational in dealing with stressful situations and avoid the current stresses.

Conclusion

The ability to control or reduce depression can be used as a powerful tool for all addicts to maintain their mental health. Therefore, by focusing on the above results and the impact of these two therapies, it can be concluded that better and more differentiated treatment effects on acceptance-based treatment and commitment to cognitive-behavioral therapy will be more effective in improving the quality of life of leaving women. Limitations of this study: that only women aged 30 to 45 years are leaving the high school to university in Isfahan province and should be cautious in generalizing its results to other communities of women as well as considering the study population. Women leaving low quality methamphetamine (glass) cannot generalize the results to improve the lives of other low quality women in society. The number of sessions for treatment was based on specific acceptance and commitment and cognitive behavioral therapy. The follow-up was a one-step follow-up followed by three months of follow-up and the lack of dose control of women at the beginning of the study and the possibility of a longitudinal study due to their high cost, difficulty, and non-commitment to the study, which was done cross-sectionalally. Longitudinal study provides more accurate and important results and time and place limitation of execution and selection were other limitations of this study.

Conflicts of Interest:

The author declares that, there is no conflict of interest.

Authors' contributions:

Authors have the equal contribution in this article.

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