ORIGINAL ARTICLE

COMPARATIVE EFFICACY OF ACCEPTANCE AND COMMITMENT THERAPY (ACT) AND DIALECTIC BEHAVIOR THERAPY (DBT) IN REDUCING AGGRESSION IN PAKISTANI YOUNG ADULTS: A QUASI-EXPERIMENTAL STUDY

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ABSTRACT

Aggression is a serious issue with adverse consequences for individuals and society. Aggression among young adults has been an emerging psychological and social problem in Pakistan, which is worsened by socioeconomic stress, family and peer conflicts, poor impulse control, and lack of emotional regulation skills. Acceptance and commitment therapy (ACT) and Dialectical Behavior Therapy (DBT) are mindfulness-based therapies that have demonstrated potential in the management of aggression in the world. Nonetheless, their relative contributions in the Pakistani context remain underexplored. The current paper sought to draw parallels between the performance of ACT and DBT in the minimization of aggression and other associated mental consequences in young adults. A stratified random sampling technique was used to select a sample of 120 young adults, with a quasi-experimental pretest-posttest control group design (Acceptance and Commitment Therapy Experimental Group (ACT EG n = 40), Dialectical Behavior Therapy (DBT EG n = 40), and Control group n = 40). The groups will include males (n=20) and females (n=20). The Buss-Perry Aggression Questionnaire (BPAQ), the Positive Mental Health Scale, the Brief Psychiatric Rating Scale (BPRS), the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), and the Depression Anxiety Stress Scales 21 (DASS-21) were used to test aggression, psychological symptoms, and functional impairments of the participants. The data was analyzed by using SPSS version 29 and Jamovi version 2.7.5. The results indicated a significant reduction in aggregate and individual aggression in the two intervention groups relative to the control group. The ACT group showed a greater decrease in overall aggression scores between pretest and the posttest (p <.001, Cohen's d=0.88) than the DBT group (p <.001, Cohen's d=0.64). Improvements were also observed in psychiatric symptoms and functional outcomes, with a large effect size observed in the ACT group. In conclusion, both Acceptance and Commitment Therapy and Dialectical Behavior Therapy were effective in reducing aggression among Pakistani young adults, with ACT demonstrating a comparatively more substantial effect. These findings support the use of evidence-based psychological Interventions for aggression management and emphasize the importance of early structured therapeutic approaches for young adult populations.

Keywords: *Acceptance and Commitment Therapy, Dialectical Behavior Therapy, Aggression, Young Adults, Pakistan*

INTRODUCTION

The issue of aggression among young adults is an emerging public health concern. This is because it is connected to interpersonal conflict, academic problems, psychological distress, and risk of violence[1,2,3,4,5,6,] as well as socioeconomic stressors, emotional dysregulation, peer conflict, and inaccessible preventive mental health services (low- and middle-income countries, including Pakistan) have been reported to be related to aggression[7,8]. Although the high incidence of aggression has been documented, the majority of empirical evidence in Pakistan has been based on cross-sectional or correlational designs and involved psychosocial predictors, including parenting styles, emotional intelligence, and use of social media[9,10,11]. Although these studies have provided crucial epidemiological insight into the causal factors of aggression, they have failed to provide evidence on the effectiveness of interventions. This is a serious gap in terms of public health since aggression is a cause of the problem not only in individual psychopathology but also in adverse effects on the larger society, such as violence, dropout, and decreased workforce productivity[12].
Mindfulness-based psychotherapy interventions, especially ACT and DBT, have shown to be effective in multiple populations in reducing aggression by increasing psychological flexibility[13,14,15], acceptance of internal experiences and values-based behavioral regulation, and emotion regulation, distress tolerance, and interpersonal effectiveness skills, respectively[16,17,18]. The comparative effectiveness of the two interventions in the management of aggression in Pakistani young adults has been under-researched.

Since the process of aggression-related outcomes is increasing and limited controlled intervention studies have been conducted in Pakistan, the current study sought to compare the efficacy of ACT

and DBT in the reduction of aggression in young adults through the quasi-experimental study design. Notably, the research questions included (1) to determine pre-post-intervention changes in aggression when administering ACT and DBT interventions, and (2) to assess whether one of the interventions resulted in significantly greater reductions in aggression than the other one or a control group. Filling this gap will support evidence-based mental health planning and aid the integration of structured psychological interventions into youth-focused public health policies[19,20].

METHODOLOGY

A quasi-experimental pretest-posttest control-group study design was used to compare the effectiveness of ACT and DBT in reducing aggression among young adults. One hundred and twenty individuals were recruited by using the stratified random sampling that determined the number of recruits by gender and randomly divided them into the Acceptance and Commitment Therapy Experimental Group (ACT EG; n = 40), the Dialectical Behavior Therapy Experimental Group (DBT EG; n = 40), and the Control Group (n = 40). In each group, there were 20 males and 20 females; gender representation was equal. The recruited participants were based in learning institutions and in the community.

Standards were evaluated based on aggression and psychological functioning to be tested through applying the Buss-Perry Aggression Questionnaire, Positive Mental Health Scale, Brief Psychiatric Rating Scale, World Health Organization Disability Assessment Schedule 2.0, and Depression Anxiety Stress Scales-21. They were applied at the baseline and post-intervention to assess aggression, emotional distress, psychiatric symptoms, and functional impairment. Data collection started with orientation, where the objective of the study, its procedures, and the rights of the participants were explained. Informed consent was also taken, and confidentiality was ensured through the coding of questions to be asked, and the data was stored in a secure place. The control measurements were carried out in a relaxing and stress-free atmosphere, and the demographic characteristics (age, gender, socioeconomic status, and academic performance) were taken to ensure that the confounding variables were eliminated. The intervention phase involved 12 sessions of individual therapy sessions per week of 60-90 minutes. The treatments were given one-on-one to reduce peer pressure. The therapists who administered both ACT and DBT were standardized and manualized, had a master's or doctoral degree in psychology, and had 3 years of clinical and practice experience after licensure. Fidelity was improved through supervision, role play training and through structured feedback.

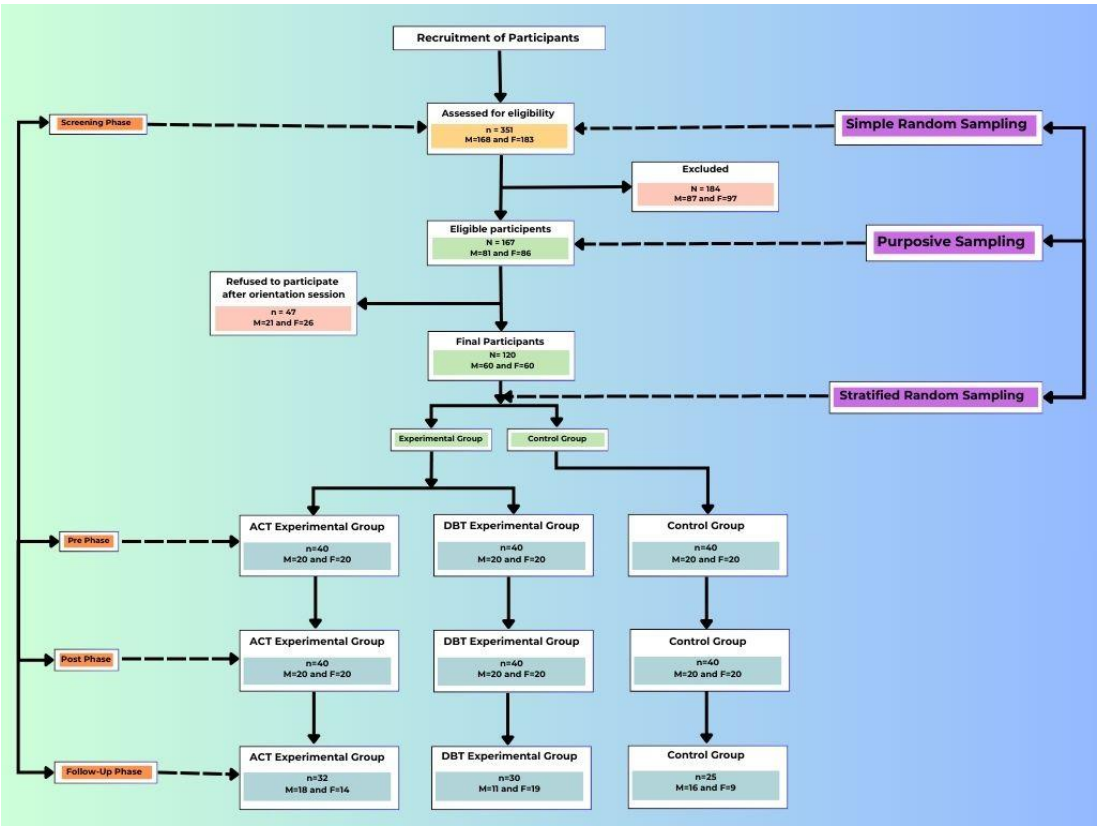

Figure 1 illustrates the participant recruitment, stratification, allocation, and retention process across study groups.

The ACT intervention entailed three parts: mindfulness, cognitive defusion, acceptance, Islamic values clarification, committed action, resilience building, and relapse prevention. The DBT intervention was also designed similarly in the way of mindfulness, distress tolerance, emotion control, interpersonal effectiveness, opposite action and relapse prevention. Psychological interventions were not given to the control group through the study period. One of the post-intervention measures was the Buss-Perry Aggression Questionnaire, which was employed to evaluate the change in aggression. The anonymized data were stored in password-protected files, and their accuracy was verified prior to data analysis. Statistical analyses were done using SPSS version 29 and Jamovi version 2.7.5. The Royal Psychologist Community Pakistan granted ethical approval for the project under the Royal Ethics Committee (Approval Date: July 3, 2023).

Table 1. Session-wise ACT and DBT Treatment Plans

Phases	ACT Treatment Plan				DBT Treatment Plan			
	Session Name	Techniques	Rational	Outcomes	Session Name	Techniques	Rational	Outcomes
Initial Phase	Session 1: Introduction to ACT and Islamic Concepts of Aggression	Ice-breaker sharing, Tug of War metaphor, reflective journaling	Established a safe space, introduced ACT concepts alongside Islamic teachings to align psychological and spiritual development	Built trust; participants understood aggression from both psychological and Islamic perspectives	Session 1: Introduction to DBT and Dialectical Thinking	Psychoeducation on DBT, goal discussion, dialectical thinking intro	Introduce DBT principles and dialectical thinking to create a framework for managing aggression	Increased motivation and foundational understanding of DBT
	Session 2: Mindfulness and Present-Moment Awareness (Islamic Integration)	Breathing exercise, River metaphor, body scan, Dhikr	Combined ACT mindfulness with Taqwa to foster calmness and reduce aggression	Participants practiced mindfulness, linked it to faith, and improved emotional regulation	Session 2: Mindfulness – Enhancing Awareness and Focus	Mindful breathing, emotional awareness training, daily practice	Improve awareness of emotions and reduce impulsive aggression	Greater emotional awareness, reduced reactivity
	Session 3: Cognitive Defusion and Detachment from Aggressive Thoughts	Passengers on the Bus metaphor, silly voice exercise	Helped participants observe and detach from aggressive thoughts by integrating ACT with Waswasa	Participants recognized and defused negative thoughts, reducing impulsive reactions	Session 3: Crisis Survival Skills for Distress	Self-soothing, distraction, radical acceptance, role-play, Ice Cube metaphor	Equip clients with skills to handle emotional crises without violence	Improved distress tolerance, reduced aggression during crises

			(Satan's whispers)					
	Session 4: Acceptance – Letting Emotions Be Without Acting on Them	Aggression recall, Clouds over Mountain metaphor, DBT-based exercises	Promoted non-reactivity to anger by encouraging acceptance and introducing Islamic value of Sabr	Participants increased emotional control and practiced patience over impulsive behavior	Session 4: Radical Acceptance and Letting Go	Radical acceptance exercises, cognitive restructuring, role-play, Mountain metaphor	Reduce anger by accepting what can't be changed	Increased emotional regulation and peaceful responses
Middle Phase	Session 5: Self-as-Context – Observing the Self Beyond Aggressive Feelings	Observing self-exercise, Sky and Clouds metaphor	Taught that individuals are more than their emotions, tied to the Islamic concept of Tazkiyah	Enhanced self-awareness, helped participants distance themselves from aggressive identity	Session 5: Emotion Regulation	Emotion identification, opposite action, body awareness, Balloon metaphor	Help clients understand and regulate emotional responses	Better emotion labeling and control of anger
	Session 6: Values Clarification – Identifying What Truly Matters	Values card sort, Compass metaphor, Quranic reflection	Clarifying values helped participants shift from aggression to peace, inspired by Rahmah and Salam	Participants aligned actions with values, promoted peace and mercy in their responses	Session 6: Interpersonal Effectiveness	DEAR MAN skills, role-play, validation training, Chessboard metaphor	Teach assertive, non-aggressive communication	Improved conflict resolution and boundary-setting
	Session 7: Committed Action – Setting Goals Based on Values	Goal setting, Garden metaphor, action planning	Motivated participants to act on values, showing long-term change is built gradually	Participants set realistic goals for reducing aggression and began acting on them	Session 7: Opposite Action	Opposite action training, role-play, Garden metaphor	Teach behavioral changes that reduce emotional escalation	Decreased automatic aggression responses
	Session 8: Obstacles to Values-	Barrier identification, problem-solving,	Recognizing and addressing fears and	Participants learned to manage	Session 8: Self-Respect and Self-	Self-validation, self-compassion training,	Reduce self-criticism and internal	Enhanced self-worth and emotional resilience

	Based Behavior	Bridge metaphor	avoidance helped sustain values-based behavior	setbacks and stay aligned with values under pressure	Validation	affirmations, Tree metaphor	sources of aggression	
	Session 9: Building Resilience Through Psychological Flexibility	Resilience sharing, Tree metaphor	Psychological flexibility fostered emotional resilience and lowered relapse risk	Participants became more adaptive under stress and confident in long-term behavior change	Session 9: Validation – Building Emotional Acceptance	Validation techniques, cognitive restructuring, Iceberg metaphor	Promote emotional validation to reduce judgment and aggression	Improved empathy and emotional understanding
Ending Phase	Session 10: Applying ACT Skills in Daily Life	Daily strategy planning, role-play, Muscle metaphor	Reinforced integration of ACT skills in everyday life, emphasizing consistency	Participants practiced ACT tools in real-life scenarios, increasing self-regulation	Session 10: Managing Triggers and Preventing Relapse	Trigger identification, relapse plan, emergency strategies, Road metaphor	Equip clients to manage high-risk situations for aggression	Increased preparedness, reduced risk of relapse
	Session 11: Relapse Prevention and Long-Term Commitment	Relapse planning, Road metaphor, long-term reflection	Prepared participants for future challenges by reinforcing skill use and values alignment	Participants created sustainable plans for long-term emotional and spiritual health	Session 11: Walking the Middle Path	Middle path discussion, role-play, Two Tracks metaphor	Integrate acceptance and change for balanced behavior	Better decision-making under emotional strain
	Session 12: Final Reflection and Closing	Final reflection, feedback sharing, commitment summary	Reinforced that therapy is a continuous journey, not an endpoint	Participants felt empowered, supported, and committed to long-term personal growth	Session 12: Final Review and Skill Consolidation	Skills review, long-term planning, client reflection, Journey metaphor	Reinforce skills and prepare for ongoing emotional management	Sustained emotional growth and DBT application

RESULTS

Table 2 indicates that 120 young adults were randomly assigned to three groups: the Control group, the DBT group, and the ACT group (n = 40). The mean age of all participants was 1825 years. The gender ratio was 1:1 (50% boys, 50% girls). The level of education was comparable between Bachelor's (49.2) and Master's (50.8) levels. All respondents were Muslim. It was found that socioeconomic status was distributed evenly across low (30%), middle (40%), and high (30%) income levels, thereby enhancing comparability of the baselines across groups.

Table 2. Sociodemographic Characteristics of Young Adults (N = 120)

Variable	Category	n	%
Group	Control	40	33.3
	DBT	40	33.3
	ACT	40	33.3
Gender	Male	60	50.0
	Female	60	50.0
Education	BS	59	49.2
	MS	61	50.8
Socioeconomic Status	Low	36	30.0
	Middle	48	40.0
	High	36	30.0

Table 3 shows the descriptive statistics and internal consistency estimates of the Aggression Questionnaire. The total aggression scale was also highly reliable (α = 0.93). The acceptable to good reliability of physical aggression (= 0.82), hostility (= 0.81), and anger (= 0.72) was observed. Verbal aggression had less internal consistency (0.60). Mean scores are moderate to high across the aggression, physical, and hostility domains.

Table 3. Descriptive Statistics and Psychometric Properties for Aggression Questionnaire and Subscales

Scales	Item	M	SD	α	Range
Aggression	29	77.43	19.92	.93	29-145
Physical Aggression	9	23.78	6.90	.82	9-45
Verbal Aggression	5	13.30	3.48	.60	5-25
Anger	7	18.50	5.36	.72	7-35
Hospitality	8	21.93	6.34	.81	8-40

Table 4 shows pre-post comparisons, which show different ranges within groups. Small, statistically significant changes with small-to-moderate effect sizes were observed in the Control group, consistent with nonspecific or observational effects. Conversely, both DBT and ACT groups had significant improvements in all the domains of aggression. The effect sizes were considered conservative. Although Cohen's d values were substantial, particularly for ACT, they indicate a significant treatment-related change within a repeated-measures design rather than a between-group standardized difference.

Table 4. Within-Group Pre-Post Effect Sizes (Cohen's d)

Outcome	Control	DBT	ACT
Physical Aggression	0.67	3.48	5.35
Verbal Aggression	0.93	2.76	2.80
Anger	1.03	3.72	3.95
Hostility	0.90	4.09	4.52
Total Aggression	1.36	6.86	13.96

Table 5 indicates that repeated-measures analyses showed significant Group × Time interaction effects, which means that the transition in aggression with time varied significantly in intervention conditions. The greatest interaction effects were found on hostility and total aggression.

Table 5. Group × Time Interaction Effects

Outcome	F	p	Partial η^2
Physical Aggression	5.49	0.005	0.08
Verbal Aggression	3.04	0.051	0.05
Anger	6.12	0.003	0.09
Hostility	7.56	< 0.001	0.11
Total Aggression	8.91	< 0.001	0.13

The post hoc analysis at the post-test in Table 6 revealed that the ACT group was significantly better than the Control group across all levels of aggression. Verbal aggression and total aggression were also reduced better with ACT than with DBT. DBT showed substantial improvement relative to Control in anger and hostility. Table 7 indicates that male participants scored higher than female participants on physical aggression, verbal aggression, and overall aggression, suggesting that males were more likely to manifest aggression through physical behaviors. Nevertheless, there was no gender difference in anger or hostility, indicating that males and females exhibited similar levels of both. These results point out that the gender variation in aggression among young adults is realized mainly in the behavioral aspects but not in the emotional aspects.

Table 6. Significant Post Hoc Comparisons at Post-Test

Outcome	Comparison	Mean Difference	p
Physical Aggression	Control vs ACT	10.67	0.036
Verbal Aggression	Control vs ACT	6.67	0.001
	DBT vs ACT	4.83	0.016
Anger	Control vs DBT	7.33	0.014
	Control vs ACT	8.50	0.005
Hostility	Control vs ACT	8.33	0.012
Total Aggression	Control vs ACT	34.17	0.003

Table 7. Sex Disagreements in Aggression.

Variable	Males (n = 60) Mean ± SD	Females (n = 60) Mean ± SD	t(118)	p-value	Cohen's d
Physical Aggression	24.90 ± 6.06	22.48 ± 6.57	2.09	0.038	0.38
Verbal Aggression	15.65 ± 4.17	13.88 ± 4.19	2.31	0.022	0.42
Anger	18.77 ± 4.77	17.48 ± 4.38	1.54	0.127	0.29
Hostility	22.23 ± 5.84	20.27 ± 5.54	1.89	0.061	0.34
Total Aggression	81.55 ± 16.90	74.12 ± 16.67	2.43	0.017	0.44

DISCUSSION

The current research investigated the relative efficacy of Acceptance and Commitment Therapy and Dialectical Behavior Therapy in minimizing aggression among Pakistani young adults. The data show that the two interventions were effective in reducing aggression compared with the control group, and the effect of ACT was greater and more consistent, particularly for total aggression and the behavioral dimensions of physical and verbal aggression[13,15]. The superior results in the ACT group indicate that interventions that focus on changing how the individual relates to aggressive thoughts and feelings, rather than attempting to suppress or manage them, can have a greater impact on impulsive behavioral responses[14,16]. The given interpretation is coherent with current process-based theories of psychopathology, which distinguish the mechanisms of experiential avoidance and cognitive rigidity as the key factors behind aggression[17,18].

DBT also had significant effects, particularly on anger and hostility, consistent with its purported focus on emotion regulation and distress tolerance[15,19]. Nonetheless, the relative decreases in behavioral aggression are more minor, suggesting that skills training alone may be less effective when inflexible thought patterns or value conflicts perpetuate aggression. The significant Group × Time interaction indicates that the decreases in aggression were not attributable to time or repeated assessment but were intervention-specific. This highlights the need to implement early, systematic psychological interventions rather

than passive or non-specific aggression-management methods for public health purposes[20]. In line with the previous studies in the region, males were found to have higher levels of baseline physical aggression, verbal aggression, and total aggression[6,9]. However, the differences were insignificant after intervention, and thus the two therapy types- ACT and DBT were found to be effective in both sexes. This result underscores how evidence-based therapies can decrease patient gender differences in aggression[21].

Several limitations must be considered. First, formal fidelity monitoring with independent raters was not conducted, leaving the therapists' training and supervision unassessed and introducing the potential for therapist-related variance[22]. Second, cultural aspects were described descriptively, and there was no empirical test or operationalization of cultural adaptation, thereby precluding causal interpretation and the assessment of potential lasting effects[23]. Lastly, the non-clinical sample may limit the generalizability to clinical or forensic populations[24].

CONCLUSION

This research has offered a demonstration that both Acceptance and commitment therapy and Dialectical behavior therapy are effective approaches when it comes to the reduction of aggression levels in Pakistani young adults. ACT presented a relatively greater and more sustained decrease in areas of aggression, specifically, behavioral and total aggression, and DBT demonstrated significant gains in the emotion-related regions, such as anger and hostility. Notably, gender differences in baseline aggression levels were removed after the intervention, indicating that the intervention's effects were comparable across genders[21].bThese results suggest the cultural superiority of one intervention over another. Instead, they emphasize the importance of evidence-based, process-oriented psychological treatment of aggression within young adult groups[14,17]. Under the prism of population health, the integration of structured interventions (ACT and DBT) into mental health planning can help to decrease aggression-related harm and enhance psychosocial functioning[20]. It needs to conduct additional studies on the long-term follow-up, better implementation strategies, and informed mental health planning at the policy level[24].

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