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Effects of Schema Therapy and ISTDP on Resilience, Emotion Regulation, and Self-Compassion in Women with a History of Trauma

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ABSTRACT

The present study aimed to compare the effectiveness of schema therapy and intensive short-term dynamic psychotherapy (ISTDP) on resilience, emotion regulation, and self-compassion in women with a history of trauma. The study employed a quasi-experimental design with pre-test, post-test, and three-month follow-up, including a control group. The statistical population consisted of women aged 20 to 45 years in Hamadan, Iran, in 2025. A total of 60 participants were initially selected using purposive sampling and assigned to three groups (schema therapy, ISTDP, and control), each consisting of 20 participants. Due to attrition, the final sample included 49 participants. The experimental groups received 15 sessions of intervention (90 minutes each), while the control group received no intervention. Data were collected using the Connor–Davidson Resilience Scale (Connor & Davidson, 2003), the Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004), and the Self-Compassion Scale–Short Form (Raes et al., 2011). Data were analyzed using mixed-design repeated-measures analysis of variance. The results indicated that both schema therapy and ISTDP significantly improved resilience, emotion regulation, and self-compassion compared to the control group ($p < .001$). Additionally, the interaction effect of time and group was significant for all variables, indicating different patterns of change across groups. The findings also showed that ISTDP was more effective than schema therapy in improving emotion regulation, while no significant difference was observed between the two treatments in resilience and self-compassion. Overall, the findings suggest that both schema therapy and ISTDP are effective interventions for improving psychological functioning in women with trauma. However, ISTDP may be particularly beneficial for enhancing emotion regulation.

Keywords: *schema therapy, intensive short-term dynamic psychotherapy, resilience, emotion regulation, self-compassion, trauma, women*

1. Introduction

Early research on trauma predominantly focused on male samples, particularly examining soldiers' responses to war-related trauma. At the same time, researchers studying sexual violence against women identified similar symptom patterns in women and men exposed to war. This led to increased research attention to women's experiences of trauma (1). The experience of trauma in women is associated with numerous negative psychological outcomes, especially post-traumatic stress disorder (PTSD) (2). Women are more likely than men to be exposed to high-risk traumas such as childbirth-related trauma and sexual assault (3, 4). Gender differences in fear processing (fear acquisition and extinction) indicate that women

exhibit greater fear acquisition and more intrusive memories. Overall, women show greater vulnerability to comorbid psychiatric disorders, higher exposure to interpersonal violence, increased fear learning, impaired fear extinction, and more frequent intrusive memories (3).

Among helping professionals, increasing attention has been paid in recent years to the high prevalence of trauma in the general population and the needs of individuals who have experienced trauma. The term "trauma" is derived from the Greek word trauma (τραύμα), meaning "wound" (5). According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), trauma refers to exposure to events such as actual or threatened death, serious injury, or sexual violence (6). One of the more recent conceptualizations suggests that trauma is not merely "an event," but rather an experience formed through the interaction between the event, context, meaning, and individual response; thus, an event may be traumatic for one person but not for another (7). Trauma can be associated with a wide range of psychological pathologies, including mood and anxiety disorders (8).

Experiencing trauma is associated with lower levels of resilience (9). Psychological resilience refers to an individual's capacity to overcome highly stressful events and maintain psychological well-being despite adversity. This concept reflects mechanisms of coping and adaptation, that is, the ability to successfully adjust to change, resist the negative effects of stressors, and avoid major dysfunction following events such as trauma, accidents, tragedy, or illness (10). Resilience enables individuals to adapt to major adversities and stressors and ultimately leads to positive outcomes (11).

The existing literature suggests that individuals exposed to traumatic events may experience a general impairment in emotion regulation, regardless of the nature of the traumatic event (8). Emotion regulation refers to a set of explicit and implicit skills used to monitor, evaluate, and modify emotional responses in accordance with one's goals (12). The ability to regulate emotions is a fundamental basis for healthy development and optimal functioning across multiple domains of life. In contrast, difficulties in emotion regulation have been identified as a transdiagnostic risk factor for many mental health disorders (13). Research indicates that adaptive emotion regulation functions as a protective factor against psychological problems, whereas emotional dysregulation constitutes a vulnerability factor (14).

The experience of trauma is also associated with self-compassion (15). As a protective personality trait, self-compassion helps individuals accept negative experiences and self-criticism, thereby reducing anxiety and depression and lowering the risk of substance use. Self-compassion involves responding to personal suffering and challenges with kindness and understanding, enabling individuals to cope more effectively with difficulties (16). It encompasses being kind and understanding toward oneself, recognizing suffering as a shared human experience, and maintaining awareness and presence in the moment (17).

Schema therapy is one of the treatment approaches for individuals with trauma (18). It is an integrative psychotherapy that incorporates elements from cognitive-behavioral, experiential, interpersonal, and psychodynamic approaches, focusing on maladaptive schemas (19). Schema therapy emphasizes the modification of early maladaptive schemas (EMS) and schema modes—sets of emotional responses, behaviors, and coping strategies activated by schemas—and considers the impact of adverse childhood experiences, including trauma (20).

Another approach for the treatment of trauma is Intensive Short-Term Dynamic Psychotherapy (ISTDP) (21). ISTDP is an evidence-based psychological intervention that aims to improve mental health and functioning by enhancing skills such as self-awareness, confrontation, challenge, direct engagement, clarification, problem-solving, autonomy, coping strategies, and stress management (22). Unlike symptom-focused treatments such as cognitive-behavioral therapy, ISTDP is emotion-focused and seeks to reduce negative affect broadly by helping individuals rapidly identify and experience their true emotions and challenge internal defenses against these feelings (23, 24).

Given the broad impact of trauma on various dimensions of women's psychological functioning—including reduced resilience, impaired emotion regulation, and diminished self-compassion—and considering the role of these variables as key factors in adaptation and recovery after trauma, examining effective therapeutic interventions in this domain is of particular importance. Although schema

therapy and Intensive Short-Term Dynamic Psychotherapy (ISTDP) have each been studied separately in improving trauma-related psychological outcomes, direct comparisons of their effectiveness—particularly among women with trauma and with a simultaneous focus on resilience, emotion regulation, and self-compassion—remain limited in the research literature. This gap highlights the need for comparative studies to provide more precise evidence for selecting effective interventions. Therefore, the present study aims to compare the effectiveness of schema therapy and Intensive Short-Term Dynamic Psychotherapy (ISTDP) in increasing resilience, improving emotion regulation, and enhancing self-compassion among women with a history of traumatic experiences.

2. Methods and Materials

2.1. *Type of the Study*

The present study was a quasi-experimental study with a pre-test, post-test, and three-month follow-up design, including a control group. A mixed-design repeated-measures analysis of variance was used, in which time (pre-test, post-test, and follow-up) was considered the within-subjects factor and group (schema therapy, ISTDP, and control) was considered the between-subjects factor.

2.2. *Place and Time of the Study*

The study was conducted in Hamadan, Iran, in 2025. The intervention sessions for the two experimental groups were implemented in a counseling/clinical setting. Follow-up assessment was conducted three months after the completion of the interventions.

2.3. *Participants*

The participants of the present study were women with a history of trauma, aged between 20 and 45 years. Initially, 60 participants were recruited and assigned to three groups of 20 participants each, including schema therapy, ISTDP, and a control group. During the course of the study, some participants dropped out; therefore, the final sample consisted of 49 women, including 16 participants in the schema therapy group, 15 participants in the ISTDP group, and 18 participants in the control group.

Participants were selected using purposive sampling and were then randomly assigned to the study groups.

Inclusion criteria were:

1. being female;
2. being between 20 and 45 years old;
3. having experienced at least one traumatic event;
4. willingness to participate in the study and attend the treatment sessions;
5. not receiving other concurrent psychological interventions during the study period.

Exclusion criteria were:

1. absence from more than two treatment sessions;
2. unwillingness to continue participation in the study;
3. presence of severe psychiatric disorders requiring immediate psychiatric or medical intervention;
4. substance dependence or any acute condition that interfered with participation in the sessions; and
5. incomplete completion of the research questionnaires at any stage of assessment.

2.4. *Intervention Protocols*

Schema Therapy: The therapeutic approach used in the present study was schema therapy based on Young's model (2003). This intervention was conducted in 15 sessions, each lasting 90 minutes. The structure of the sessions is presented in Table 1.

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Table 1

Summary of Group Schema Therapy Sessions

Session	Content
Session 1	Overview of session structure and rules; introduction to schema and schema therapy; instructions for completing the Young Schema Questionnaire; establishing therapeutic alliance and trust.
Session 2	Completion of assessments; education on the relationship between schema therapy, disorders, cognitive processes, and personality; strengthening therapeutic alliance.
Session 3	Continued assessment and education; linking schemas to the "inner child"; examples of maladaptive schemas; factors contributing to schema development.
Session 4	Schema assessment through imagery; identification and activation of schemas; working with imagery related to significant others; facilitating emotional experience.
Session 5	Introduction to coping styles; reviewing coping patterns among group members; practical examples.
Session 6	Testing schema validity; gathering evidence supporting and contradicting schemas; restructuring beliefs.
Session 7	Evaluating advantages and disadvantages of coping responses; introducing schema flashcards; schema monitoring forms.
Session 8	Imagery dialogue techniques; strengthening the healthy adult mode and distancing from maladaptive schemas.
Session 9	Dialogue between the "schema mode" and the "healthy mode"; reviewing schema monitoring forms.
Session 10	Writing letters to parents; imagery dialogues using the empty-chair technique.
Session 11	Identifying target behaviors for intervention.
Session 12	Teaching behavioral change strategies; emotion and impulse regulation techniques.
Session 13	Exploring self-sacrifice and subjugation schemas.
Session 14	Exploring emotional deprivation and emotional inhibition schemas; training appropriate anger expression.
Session 15	Reviewing assignments; enhancing frustration tolerance and self-control; preparation for post-test assessment.

Intensive Short-Term Dynamic Psychotherapy (ISTDP): The therapeutic approach used in this study was Intensive Short-Term Dynamic Psychotherapy based on the protocol developed by (25), as cited in (26). This intervention was delivered in 15 sessions, each lasting 90 minutes. The structure of the sessions is presented in Table 2.

Table 2

Intensive Short-Term Dynamic Psychotherapy (ISTDP) Sessions

Session	Description
Session 1	Introduction of rules, initial interview, and preliminary assessment.
Session 2	From this session onward, interventions were selected based on the type of patients' defenses.
Session 3	Working with tactical defenses (used to distance the therapist), including vagueness, overgeneralization, and defensive language.
Session 4	Examination of tactical defenses used by the patient, such as diversification.
Session 5	Working with regressive defenses (used to avoid feelings), including avoidance and denial.
Session 6	Examination of intellectualizing and rationalizing defenses.
Session 7	Examination of displacement as a defense mechanism.
Session 8	Examination of identification with the aggressor as a regressive defense.
Session 9	Examination of isolation of affect.
Session 10	Examination of minimization as a defense.
Session 11	Examination of reaction formation.
Session 12	Examination of inhibition as a defense.
Session 13	Providing feedback on maladaptive defensive patterns and helping patients reduce them; regulating anxiety and encouraging deeper emotional experiencing.
Sessions 14–15	Helping the patient become aware of the triangle of conflict underlying their psychological difficulties.

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2.5. *Measures*

Connor–Davidson Resilience Scale (CD-RISC; (27)): This scale was developed by Connor and Davidson (2003) to assess resilience as the ability to cope with stress. The scale consists of 25 items (27). Responses are rated on a 5-point Likert scale ranging from 0 (“not true at all”) to 4 (“true nearly all the time”). Higher scores on this scale indicate greater resilience. In the original study, Cronbach’s α was reported as .86. In Iran, Cronbach’s α has been reported as .81 and a validity coefficient of .93 for the scale. In the present study, the Cronbach’s α for this questionnaire was found to be .76.

Difficulties in Emotion Regulation Scale (DERS; (28)): This 36-item scale assesses difficulties in emotion regulation across six dimensions: non-acceptance of emotional responses, difficulties in goal-directed behavior, impulse control difficulties, lack of emotional awareness, limited access to effective strategies, and lack of emotional clarity. Responses are rated on a 5-point Likert scale (1 = “almost never” to 5 = “almost always”), with higher scores reflecting greater emotion dysregulation. The original study reported Cronbach’s α = .93 and test–retest reliability = .88 (28). In Iran, Cronbach’s α has been reported between .79 and .92 and test–retest reliability between .71 and .87, indicating strong psychometric properties for both clinical and non-clinical samples. In the present study, the Cronbach's α was found as .79 for the scale.

Self-Compassion Scale–Short Form (SCS-SF; (29)): Although the long form of the Self-Compassion Scale is commonly used to assess self-compassion, Raes et al. (2011) developed the short form of the scale. This short form consists of 12 items, with responses rated on a 5-point Likert scale ranging from 1 (“almost never”) to 5 (“almost always”) (29). The scale measures three bipolar components across six subscales: self-kindness versus self-judgment, mindfulness versus over-identification, and common humanity versus isolation. The short form has shown a high correlation with the long form (r = .97) and a test–retest reliability of .92. In Iran, Cronbach’s α coefficients have been reported as .79 for the total scale and .68, .71, and .86 for the components of self-kindness/self-judgment, common humanity/isolation, and mindfulness/over-identification, respectively. In the present study, the Cronbach's α was found as .81 for the scale.

2.6. *Data Collection*

Data were collected using standardized self-report questionnaires administered at three time points: pre-test, post-test, and three-month follow-up. Prior to the intervention, participants completed the research instruments as part of the baseline assessment. Following the completion of the intervention sessions, the same measures were re-administered at post-test. A follow-up assessment was conducted three months later to evaluate the stability of treatment effects over time.

2.7. *Statistical Analysis*

Data were analyzed using SPSS software (version 26). Descriptive statistics, including means and standard deviations, were calculated for all study variables. To examine the effects of the interventions over time and between groups, a mixed-design repeated-measures analysis of variance was conducted. The assumptions of normality, homogeneity of variances, homogeneity of covariance matrices, and sphericity were tested using appropriate statistical tests (e.g., Shapiro–Wilk, Levene’s test, Box’s M test, and Mauchly’s test). When the assumption of sphericity was violated, Greenhouse–Geisser corrections were applied. Post hoc comparisons were performed using the Bonferroni test. A significance level of $p < .05$ was considered for all analyses.

3. Findings and Results

The mean age of the participants was 32.81 years (SD = 7.42), ranging from 22 to 45 years. In terms of educational level, 18 participants (36.7%) had a high school diploma or less, 25 participants (51%) held a bachelor’s degree, 4 participants (8.2%) had a master’s degree, and 2 participants (4.1%) held a doctoral degree.

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Table 3

Comparison of the mean and standard deviation of the research variables among the three groups at three time points: pre-test, post-test, and follow-up

Variable	Group	Pre-test Mean	Pre-test SD	Post-test Mean	Post-test SD	Follow-up Mean	Follow-up SD
Resilience	Schema therapy	46.00	3.38	59.18	2.99	59.81	4.24
	ISTDP	46.53	2.97	58.60	3.04	57.80	4.70
	Control	46.11	2.88	47.05	4.53	46.50	5.81
Emotion regulation	Schema therapy	111.75	9.17	93.81	10.38	95.18	9.35
	ISTDP	110.26	8.31	83.73	9.87	80.73	9.85
	Control	110.16	9.50	109.11	10.41	109.94	12.35
Self-compassion	Schema therapy	30.06	3.58	44.68	5.09	45.68	5.85
	ISTDP	29.80	4.19	41.93	4.78	41.73	6.14
	Control	31.00	4.35	30.88	5.01	31.11	4.29

Table 3 presents the mean and standard deviation of resilience, emotion regulation, and self-compassion scores in the schema therapy group, the ISTDP group, and the control group across the three assessment phases of pre-test, post-test, and follow-up. As shown, the mean scores of the research variables at pre-test did not differ substantially across the three groups. However, at post-test and follow-up, the two intervention groups showed considerable changes compared with the control group. Specifically, the mean scores of resilience and self-compassion increased in both treatment groups from pre-test to post-test and follow-up. In contrast, the mean scores of emotion regulation decreased in both treatment groups relative to pre-test, indicating improvement in emotion regulation. Changes in the control group were minimal.

The results of Box's M test for resilience (Box's M = 21.323, P = 0.082), emotion regulation (Box's M = 15.147, P = 0.321), and self-compassion (Box's M = 15.387, P = 0.307) were not significant; therefore, the assumption of homogeneity of covariance matrices was met. In addition, Levene's test indicated that for emotion regulation and self-compassion, there were no significant differences in group variances across all three phases of the study, and thus the assumption of homogeneity of variances was satisfied. For resilience, Levene's test was not significant at pre-test and follow-up; however, at post-test, based on the mean, it reached significance at the 0.049 level. Therefore, this assumption should be interpreted with caution for post-test resilience scores. The results of Mauchly's test showed that the assumption of sphericity was violated for resilience (W = 0.734, P = 0.001) and emotion regulation (W = 0.838, P = 0.019). Therefore, Greenhouse–Geisser corrected values were used for the degrees of freedom when interpreting these two variables. However, the assumption of sphericity was met for self-compassion (W = 0.887, P = 0.068).

Moreover, all multivariate tests for the effect of time and the interaction effect of time × group were significant at the 0.001 level for all three variables (P < 0.001), indicating significant differences among the groups over time and suggesting that the effectiveness of the interventions varied across the different assessment stages. To examine the exact source of these differences, univariate analyses were also conducted, the results of which are presented in Table 4.

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Table 4

Results of mixed analysis of variance examining the effects of group and assessment time on the dependent variables

Source	Effect	Dependent Variable	Sum of Squares	Df	Mean Square	F	Sig.	Effect Size
Within-subjects	Time of assessment	Resilience	2409.966	1.579	1525.795	116.181	0.001	0.716
		Emotion regulation	7612.585	1.721	4423.241	269.877	0.001	0.854
		Self-compassion	2664.753	2	1332.377	231.684	0.001	0.834
	Time of assessment × Group	Resilience	1110.032	3.159	351.391	26.757	0.001	0.538
		Emotion regulation	4305.879	3.442	1250.951	76.325	0.001	0.768
		Self-compassion	1465.317	4	366.329	63.700	0.001	0.735
	Error	Resilience	954.186	72.656	13.133	—	—	—
		Emotion regulation	1297.549	79.168	16.390	—	—	—
		Self-compassion	529.078	92	5.751	—	—	—
Between-subjects	Group	Resilience	2258.628	2	1129.314	41.504	0.001	0.643
		Emotion regulation	8146.672	2	4073.336	14.918	0.001	0.393
		Self-compassion	2323.620	2	1161.810	19.601	0.001	0.460
	Error	Resilience	1251.644	46	27.210	—	—	—
		Emotion regulation	12560.348	46	273.051	—	—	—
		Self-compassion	2726.557	46	59.273	—	—	—

According to the results reported in Table 4, the main effect of assessment time was significant for all three variables, namely resilience, $F(1.579, 72.656) = 116.18$, $p < .001$, $\eta^2 = .716$, emotion regulation, $F(1.721, 79.168) = 269.87$, $p < .001$, $\eta^2 = .854$, and self-compassion, $F(2, 92) = 231.68$, $p < .001$, $\eta^2 = .834$. These findings indicate that participants' scores changed significantly across the pre-test, post-test, and follow-up stages regardless of group membership. Furthermore, the interaction effect of assessment time and group was also significant for all three variables, including resilience, $F(3.159, 72.656) = 26.75$, $p < .001$, $\eta^2 = .538$, emotion regulation, $F(3.442, 79.168) = 76.32$, $p < .001$, $\eta^2 = .768$, and self-compassion, $F(4, 92) = 63.70$, $p < .001$, $\eta^2 = .735$, indicating that the pattern of changes over time differed significantly across the three groups. In addition, the main effect of group was significant for resilience, $F(2, 46) = 41.50$, $p < .001$, $\eta^2 = .643$, emotion regulation, $F(2, 46) = 14.91$, $p < .001$, $\eta^2 = .393$, and self-compassion, $F(2, 46) = 19.60$, $p < .001$, $\eta^2 = .460$. Therefore, it can be concluded that the overall mean scores of these variables differed significantly among the three groups.

To examine the differences between the assessment stages more precisely, Bonferroni post hoc tests were used. The results showed that for all three variables, the differences between pre-test and post-test and between pre-test and follow-up were significant, whereas the difference between post-test and follow-up was not significant. In other words, the changes produced after the intervention remained largely stable at follow-up. More specifically, for resilience, the mean difference between pre-test and post-test was -8.733, and between pre-test and follow-up it was -8.489; both were significant, whereas the difference between post-test and follow-up was not significant. For emotion regulation, the mean difference between pre-test and post-test was 15.175, and between pre-test and follow-up it was 15.439; both were significant at the 0.001 level, whereas the difference between post-test and follow-up was not significant ($P = 1.000$). For self-compassion, the difference between pre-test and post-test was -8.882, and between pre-test and follow-up it was -9.223; both were significant, whereas the difference between post-test and follow-up was not significant.

To compare pairwise mean differences among the groups, Bonferroni post hoc tests were also conducted, the results of which are presented in Table 5.

Table 5

Pairwise comparison of group means in the research variables

Variable	Group 1	Group 2	Mean Difference	Significance Level
Resilience	Schema therapy	ISTDP	0.69	1.000
	Schema therapy	Control	8.44	0.001
	ISTDP	Schema therapy	-0.69	1.000
	ISTDP	Control	7.75	0.001
	Control	Schema therapy	-8.44	0.001
	Control	ISTDP	-7.75	0.001
Emotion regulation	Schema therapy	ISTDP	8.67	0.045
	Schema therapy	Control	-9.49	0.017
	ISTDP	Schema therapy	-8.67	0.045
	ISTDP	Control	-18.16	0.001
	Control	Schema therapy	9.49	0.017
	Control	ISTDP	18.16	0.001
Self-compassion	Schema therapy	ISTDP	2.32	0.458
	Schema therapy	Control	9.14	0.001
	ISTDP	Schema therapy	-2.32	0.458
	ISTDP	Control	6.82	0.001
	Control	Schema therapy	-9.14	0.001
	Control	ISTDP	-6.82	0.001

The results presented in Table 5 indicate that, for emotion regulation, significant differences existed among all three groups. Based on the mean values, ISTDP produced a greater reduction in emotion regulation scores than schema therapy and, from this perspective, demonstrated greater effectiveness. In addition, both treatments were more effective than the control group. For resilience, the difference between schema therapy and ISTDP was not significant; however, both treatments significantly increased resilience compared with the control group. Similarly, for self-compassion, the difference between the two treatment groups was not significant, but both interventions had a significant effect in increasing self-compassion relative to the control group.

Overall, the findings of the present study indicate that both schema therapy and ISTDP in women with trauma led to improved emotion regulation, increased resilience, and enhanced self-compassion. However, for the emotion regulation variable, ISTDP showed greater effectiveness than schema therapy, whereas for resilience and self-compassion, no significant difference was observed between the two treatments, and both were equally effective.

4. Discussion and Conclusion

The present study aimed to compare the effectiveness of schema therapy and intensive short-term dynamic psychotherapy (ISTDP) on resilience, emotion regulation, and self-compassion in women with a history of traumatic experiences. The results showed that both schema therapy and ISTDP were effective in increasing resilience and self-compassion and in improving emotion regulation compared to the control group. However, ISTDP demonstrated greater effectiveness in improving emotion regulation compared to schema therapy, while no significant difference was found between the two treatments in resilience and self-compassion.

Regarding resilience, schema therapy may enhance resilience by targeting early maladaptive schemas and schema modes rooted in adverse and traumatic experiences (18, 20). By identifying and modifying these maladaptive patterns and strengthening healthier modes, individuals may reinterpret stressful experiences more adaptively and develop healthier coping responses, which can support resilience (10, 30). In terms of emotion regulation, schema therapy appears to improve this domain by increasing awareness of emotional patterns and addressing maladaptive coping responses such as avoidance, surrender, and overcompensation (19, 31). By working on schema

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modes and strengthening the Healthy Adult mode, individuals may gradually learn to regulate their emotions more effectively (30, 32). With respect to self-compassion, schema therapy may contribute by reducing punitive and self-critical internal states and by strengthening healthier, more compassionate modes of relating to the self (30, 31). Techniques such as imagery rescripting and limited reparenting may help foster self-kindness, emotional acceptance, and a more supportive inner dialogue, all of which are closely related to self-compassion (19, 30).

Regarding resilience, ISTDP may enhance resilience by facilitating direct emotional processing and reducing defensive patterns that interfere with adaptive functioning (25, 33). By helping individuals confront avoided emotions and unresolved conflicts, this approach may promote more adaptive coping and strengthen the individual's capacity to deal with stress (24, 33). In terms of emotion regulation, ISTDP appears to be particularly effective because it directly targets emotional experience, anxiety regulation, and defense mechanisms (14, 34). Through intensive focus on moment-to-moment emotional processes, individuals are encouraged to experience and tolerate their feelings rather than avoid them, which may lead to more adaptive emotion regulation over time (24, 33). With respect to self-compassion, ISTDP may contribute more indirectly by reducing harsh self-judgment and increasing emotional awareness and acceptance (33, 35). As individuals gain greater insight into their emotional experiences and underlying conflicts, they may gradually develop a more accepting and compassionate attitude toward themselves (33, 35).

The greater effectiveness of ISTDP in improving emotion regulation can be explained by its strong emphasis on emotional processing and its direct focus on defenses and anxiety. Unlike schema therapy, which works more gradually through cognitive and experiential techniques, ISTDP actively challenges defenses in real time and helps individuals access core emotions more rapidly. This immediate engagement with emotional experience allows for deeper and faster changes in emotional regulation processes, which may explain its superior effectiveness in this domain.

Overall, the findings of the present study indicate that both schema therapy and ISTDP are effective interventions for improving resilience, emotion regulation, and self-compassion in women with trauma. While ISTDP showed greater effectiveness in improving emotion regulation, both treatments were similarly effective in enhancing resilience and self-compassion.

These results have important clinical implications, suggesting that both approaches can be used as effective treatment options for individuals with trauma-related difficulties. Given the stronger effect of ISTDP on emotion regulation, it may be particularly beneficial for individuals with severe emotional dysregulation.

Authors' Contributions

All authors contributed substantially to the study and to manuscript development, and all approved the final version.

Declaration

Artificial intelligence was used only for language polishing, academic editing, organization of the manuscript, and generation of visual figures from the numerical results supplied by the authors. AI was not used to collect data, perform the statistical analyses, fabricate findings, or generate unverifiable references. The authors reviewed and verified the final manuscript and remain fully responsible for its content.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethics Considerations

The study placed a high emphasis on ethical considerations. Informed consent obtained from all participants, ensuring they are fully aware of the nature of the study and their role in it. Confidentiality strictly maintained, with data anonymized to protect individual privacy. The study adhered to the ethical guidelines for research with human subjects as outlined in the Declaration of Helsinki.

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