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The Effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) on Self-Compassion and Defense Mechanisms in Individuals with Depression

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ABSTRACT

Objective: The aim of the present study was to determine the effectiveness of Intensive Short-Term Dynamic Psychotherapy (ISTDP) on self-compassion and defense mechanisms in individuals with depression.

Methods and Materials: The research method was quasi-experimental with a pretest-posttest-follow-up design and a control group. The statistical population of this study included all individuals with mild depression who referred to healthcare centers in districts four and six of Tehran during the spring and summer of 2023. Using convenience sampling and inclusion/exclusion criteria, 30 individuals were selected and randomly assigned to the intervention and control groups. Participants responded to the Self-Compassion Scale (Neff, 2003) and the Defense Style Questionnaire-40 (Andrews et al., 1993) for pretest, posttest, and follow-up assessments. After the implementation of ISTDP for the experimental group, the data were analyzed using repeated measures ANOVA.

Findings: The results indicated that ISTDP increases self-compassion in individuals with depression. Moreover, ISTDP increases the use of mature defense mechanisms and decreases the use of immature and neurotic defense mechanisms in individuals with depression.

Conclusion: In conclusion, Intensive Short-Term Dynamic Psychotherapy (ISTDP) effectively increases self-compassion and enhances the use of mature defense mechanisms while reducing the use of immature and neurotic defenses in individuals with depression. These findings suggest that ISTDP can be a valuable therapeutic approach for improving emotional regulation and reducing depressive symptoms through deeper emotional integration and resolution of unconscious conflicts.

Keywords: *depression, self-compassion, Intensive Short-Term Dynamic Psychotherapy, defense mechanisms*

1. Introduction

Depression, which currently affects more than 264 million people worldwide and is ranked as the leading cause of disability globally, is one of the most common mental disorders, associated with reduced quality of life, increased mortality, and high healthcare costs (Wienicke et al., 2023). Depression is a common psychological issue that arises from the complex interaction of cognitive, behavioral, and biological factors and symptoms (Safari & Aftab, 2021). Depression is the most prevalent psychiatric disorder, drawing significant attention from mental health professionals due to its high prevalence and healthcare costs (Aftab, 2016).

Research indicates that certain human abilities, including self-compassion, play a protective role against mental health issues (Egan et al., 2022; Han & Kim, 2023; Körner et al., 2015). An increasing body of evidence suggests that self-compassion may play a significant role in reducing depressive symptoms in various populations, including both clinical (e.g., individuals with major depressive disorder) and non-clinical groups (Egan et al., 2022; Han & Kim, 2023; Körner et al., 2015). Self-compassion refers to the act of caring for and understanding oneself with empathy rather than adopting a critical and harsh perspective toward oneself (Gilbert, 2010). Bluth and Blanton (2014) suggested that increasing self-compassion in individuals with depression may reduce self-criticism (Bluth & Blanton, 2014). It appears that when individuals become increasingly aware of their stream of thoughts, they can recognize the extent to which these thoughts are critical and harmful, enabling them to judge their behaviors with more kindness, ultimately leading to well-being. In such cases, compassionate and gentle responses are elicited without hindering, avoiding, or controlling experiences and stimuli, thus creating psychological distance between the self and emotions, allowing individuals to regulate emotions in a way that minimizes emotional consequences (Grecucci et al., 2015).

Studies have shown that resorting to various defense mechanisms and avoiding unpleasant internal emotions exacerbates negative mood and depression (Nikoseresht & Shomali Askouei, 2021; Ziadni et al., 2017). Excessive and inappropriate use of defense mechanisms can prevent effective coping responses, as emotional and avoidant coping is associated with greater depressive symptoms (Iwanicka et al., 2017). Defense mechanisms are automatic regulators that reduce cognitive dissonance and minimize sudden changes in internal and external reality by influencing how threatening events are perceived. Dysfunction in defense mechanisms can result in deficits in recognizing and expressing emotions (Prout et al., 2019). Negative emotions such as anxiety, guilt, and sadness arise from unconscious conflicts, and their function is to activate defenses (Caligor et al., 2007). Maladaptive coping and emotional regulation mechanisms are employed to protect against painful emotions (Rice & Hoffman, 2014).

While antidepressants are commonly used to treat depression, many patients prefer psychotherapy. After cognitive-behavioral therapy, Intensive Short-Term Dynamic Psychotherapy (ISTDP) is a widely used treatment for depression in clinical studies (Wienicke et al., 2023). Cognitive-behavioral therapy has been conceptualized in various ways for depressed patients, focusing on the acceptance of emotions as a core therapeutic mechanism to achieve positive outcomes. However, evidence shows that not all patients respond to these treatments, particularly those with more severe and complex symptoms who avoid their deeper-rooted emotions (Thoma & Abbass, 2022). One type of psychodynamic intervention used in the treatment of depression is ISTDP. ISTDP involves a series of techniques designed to address problems based on the aforementioned model. In this approach, clarification of defenses, followed by pressure to experience emotions and challenge defensive barriers, begins at the start of the treatment process. The application of these techniques leads to the movement of intense and combined emotions in the transference (the patient-therapist relationship), activating the layers of defenses woven into the patient's self against these emotions. This conflictual situation reawakens similar conflicts from the patient's past. Proper use of these techniques has repeatedly shown that if the patient's defense system is broken, and the patient's emotions are directly touched and expressed in the transference, the unconscious experiences and traumas that contributed to the pathology will be revealed (Davanloo, 1995a, 1995b). According to the underlying assumption of ISTDP, individuals experience anxiety to prevent emotions and feelings from entering the conscious mind. As a result of this anxiety, the individual's psychological defense mechanisms are automatically activated, exerting a strong influence on the individual's functioning (Sharpless et al., 2022).

Research indicates the effectiveness of ISTDP on depressive symptoms, self-compassion, and defense mechanisms in various populations. For example, Mahboudi et al. (2022) conducted a study on a sample of men with

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social anxiety disorder and found that ISTDP was effective in increasing self-esteem, mature defense styles, and reducing immature and neurotic defense styles, as well as emotional regulation difficulties in men with social anxiety (Mahboudi et al., 2022). Alirezai et al. (2022) conducted a study on a sample of 30 women with cancer in Gorgan, showing that both ISTDP and cognitive-behavioral therapy significantly increased self-compassion in cancer patients, with no significant difference in the effectiveness of the two treatments (Alirezaei et al., 2022). Punzi and Lindgren (2018) conducted a study on nine patients with substance use disorders and a history of childhood trauma, demonstrating that short-term psychodynamic therapy was effective in improving interpersonal dependency, emotional regulation, and defense mechanisms in patients with substance use disorders (Punzi & Lindgren, 2019).

From reviewing the existing studies, it is apparent that ISTDP is an effective treatment for depressive symptoms and related constructs; however, a research gap is observed due to the dispersion of available studies. Therefore, the present study aimed to answer the following question: Is ISTDP effective in improving self-compassion and defense mechanisms in individuals with depression?

2. Methods and Materials

2.1. *Study Design and Participants*

This applied study employed a quasi-experimental method with a pretest-posttest-follow-up design and a control group. The statistical population of this study included all individuals with mild depression residing in Tehran during the spring and summer of 2023. Among them, individuals who visited the Yara Clinic in district four of Tehran and the MindVision Counseling Center in district six of Tehran and were diagnosed with mild depression were selected as the statistical sample through convenience sampling. In this study, the sampling method involved examining the inclusion and exclusion criteria among 58 individuals diagnosed with depression at the Yara Clinic. Afterward, the researcher identified the individuals willing to participate, resulting in 41 individuals agreeing to cooperate, from which 30 were randomly selected and randomly assigned to the experimental and control groups.

Inclusion criteria were a score above the mild-to-moderate cutoff on the Beck Depression Inventory and an age range of 25 to 45 years. Exclusion criteria included receiving two treatments simultaneously, concurrent use of antipsychotic medications, having chronic physical diseases or intellectual and physical disabilities, and having other types of depression not included in the present study, such as postpartum depression or seasonal depression, co-occurring disorders with depression, participation in another therapy program simultaneously, or experiencing the loss of a loved one in the past three months.

After obtaining the necessary permissions for conducting the research from the relevant authorities at Islamic Azad University, Rudehen Branch, the preliminary phase of the research was carried out. The Yara Clinic and MindVision Counseling Center in Tehran were selected as available centers, and the inclusion and exclusion criteria were assessed through preliminary questions posed to individuals who visited these centers. Of those who met the conditions for participation in the present study, 30 individuals were selected as the final sample and randomly assigned to experimental and control groups. It is important to note that before completing the questionnaires, participants were informed about the anonymity of the data, confidentiality, and their right to withdraw from the study at any time. After random assignment to the experimental and control groups, participants in the experimental group received 12 sessions of intervention. According to the research design, the changes in self-compassion, defense mechanisms, and depression scores were assessed not only in the pretest (session 1, time 1) but also at the end of the 12th session (time 2, posttest) and two months after the intervention (follow-up, time 3). The follow-up phase in this study involved contacting participants two months after the intervention to invite them to complete the questionnaires again in order to assess the sustainability of the intervention's effects on self-compassion, defense mechanisms, and depression.

2.2. *Measures*

2.2.1. *Depression*

The Beck Depression Inventory consists of 21 items, asking respondents to rate the severity of symptoms on a scale of zero to three. The cutoff points for this inventory are reported as 0-13 for minimal depression, 14-19 for mild depression, 20-28 for moderate depression, and 29-63 for severe depression. Jo et al. (2008) reported a Cronbach's alpha coefficient of 0.94, item-total correlations ranging from 0.47 to 0.70, and a correlation with the revised Hamilton Depression Rating Scale of 0.66, indicating good validity. In Iran, Hamidi et al. (2015) reported a Cronbach's alpha of 0.93 for this tool and a correlation of 0.8 with the

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General Health Questionnaire as an indicator of convergent validity (Nikoseresht & Shomali Askouei, 2021).

2.2.2. *Self-Compassion*

The Self-Compassion Scale (Neff, 2003) consists of 26 items assessing six components: self-kindness (items 5, 12, 19, 26, and 23), self-judgment (items 2, 6, 20, and 24), mindfulness (items 1, 8, 11, 16, and 21), over-identification (items 3, 7, 10, and 15), common humanity (items 4, 13, 18, and 25), and isolation (items 9, 14, 17, and 22), using a Likert scale ranging from 1 (almost never) to 5 (almost always). Neff (2003) reported a Cronbach's alpha of 0.92 for this tool and a correlation of -0.51 with the Beck Depression Inventory and -0.65 with the Spielberger State-Trait Anxiety Inventory (Spielberger, 1970). In Khosravi et al.'s (2013) study, exploratory factor analysis confirmed the six-factor structure of the questionnaire. Khosravi et al. (2013) reported Cronbach's alpha coefficients of 0.86 for the entire tool and 0.81, 0.79, 0.84, 0.85, 0.80, and 0.83 for the subscales of self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification, respectively (Khosravi et al., 2013).

2.2.3. *Defense Style*

The Defense Style Questionnaire-40 consists of 40 items assessing 20 defense mechanisms at three levels: mature (items 2, 3, 5, 25, 26, 30, 35, 38), neurotic (items 1, 7, 21, 24, 28, 32, 39, 40), and immature (items 4, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 27, 29, 31, 33, 34, 36, 37), rated on a 9-point Likert scale ranging from 1 (strongly disagree) to 9 (strongly agree). Andrews et al. (1993) reported Cronbach's alpha coefficients of 0.68, 0.58, and 0.80 for the subscales of mature, neurotic, and immature defense mechanisms in two groups (healthy and anxious). Andrews et al. (1993) found significant differences in mature ($F = -0.95$, $p < 0.05$), neurotic ($F = 0.40$, $p < 0.05$), and immature ($F = 0.44$, $p < 0.05$) defense mechanisms between anxious and healthy individuals. In Iran, Heidari Nasab et al. (2007) reported Cronbach's alpha coefficients of 0.81 and 0.87, and correlations of this tool with the revised NEO Personality Inventory as satisfactory indicators of validity (Heidari Nasab et al., 2014).

2.3. *Intervention*

The ISTDP method was developed by Davonloo, who transformed the long-term, less effective, disorganized, and vague nature of traditional psychoanalysis into a short-term, effective, organized, and clear approach. This therapeutic method is referred to as dynamic because, like psychoanalysis, it is based on the experience of real emotions, overcoming resistance, and a precise focus on the transference phenomenon. However, its conceptualization of the unconscious, the pathogenic factors, and the therapeutic technique is radically different from other psychoanalytic frameworks. The central axes of this therapeutic approach are based on the nature of therapeutic relationships and disclosure (Davanloo, 1995a, 1995b; Ghorbani, 2019).

Stage 1: Trial Therapy – Assessment of the Patient's Problems and Initial Ability to Respond to Therapy

The first session of treatment, following Davanloo's method, is a trial therapy session. In this stage, the focus is on assessing the patient's problems and evaluating their initial capacity to respond to therapy. The therapist examines the nature of the patient's problem and requests a specific, concrete example of it. Throughout the questioning process, emphasis is placed on personal, clear, and concrete explanations to enhance the clarity of the patient's narrative. This stage is essential for assessing the patient's emotional tolerance. Patients may enter therapy in one of four states: emotional activation, anxiety activation, defense activation, or none of these. The questioning continues until a signal (defense, anxiety, or emotion) is activated. Depending on the patient's state, the therapist focuses on regulating anxiety, clarifying and challenging defenses, or helping the patient fully experience emotions on cognitive, physical, and impulsive levels.

Stage 2: Pressure for Clearer Responses and Emotional Experience

In the second stage, the therapist progressively pushes the patient for more specific and concrete responses. This gradually activates the patient's primary defense systems. The therapist asks the patient to describe specific events or experiences that have caused problems. The interview is guided toward anxiety-provoking topics, encouraging the patient to provide more precise, objective answers. This stage increases the emotional tension, leading to the activation of defenses, which prepares the patient for deeper emotional exploration.

Stage 3: Identifying, Clarifying, and Challenging Defenses

After the pressure for clear responses, the patient's defense mechanisms become activated. The therapist then shifts to analyzing and challenging these defenses, as the goal of this therapy is to help the patient experience emotions

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at the highest level. All defenses that obstruct emotional experience are identified and challenged. The therapist's role is to clarify the nature of the defenses and question the patient's defensive behaviors. At this stage, the therapist helps the patient understand how their defenses prevent them from fully experiencing their emotions. The therapist also emphasizes that these defenses are counterproductive to the therapeutic process.

Stage 4: Transference Resistance

In this stage, the therapist is attentive to signs of transference, often expressed non-verbally, such as clenching fists, gripping the chair, or sighing. When sufficient tension has built, the therapist directly addresses the transference. The patient's attention is directed toward non-verbal cues that reveal emotional resistance. The therapist increases the intensity of challenges to the patient's defenses related to the transference feelings. As the resistance becomes more apparent, the therapist confronts the patient's avoidance of emotional closeness to the therapist, framing it as self-sabotaging behavior. This stage is crucial for breaking down the defenses preventing emotional connection in therapy.

Stage 5: Direct Access to the Unconscious

In the fifth stage, the focus shifts from defenses to directly accessing and experiencing emotions in the transference. The therapist continues to apply pressure and challenge the defenses until signs of emotional activation from the unconscious emerge. The goal is to facilitate the patient's direct experience of their emotions, often leading to the uncovering of repressed feelings. As the patient's emotional intensity increases, the therapist helps the patient express and understand their feelings in a complete and multi-dimensional way, including cognitive, physical, and impulsive aspects.

Stage 6: Systematic Analysis of Transference

Following the breakthrough of emotional expression, the tension within the patient significantly decreases, and a therapeutic alliance strengthens. In this stage, the therapist systematically analyzes the transference by exploring the parallels between the patient's transference patterns with the therapist and their relationships in the present and past. This analysis is guided by Davanloo's conflict triangle and person triangle, helping to connect the patient's transference experiences to their broader relational patterns.

Stage 7: Dynamic Exploration of the Unconscious

In the final stage, due to the established therapeutic alliance, traumatic events and unconscious emotions, such as anger, sadness, and guilt, are uncovered and experienced. The therapist facilitates the patient's insight into these experiences. After systematically analyzing the transference and applying the conflict and person triangles, the therapist further explores the patient's current and past relationships. By examining the patient's family and personal history, the therapist brings deeper unconscious conflicts to light. Although painful feelings may trigger some resistance, the therapist continues to challenge this resistance, allowing the patient to fully experience and process their most painful emotions.

2.4. Data analysis

In this study, descriptive statistics such as mean and standard deviation were used to examine demographic variables, t-tests and chi-square tests were used for group comparisons, and repeated measures ANOVA was used for data analysis with SPSS-22 software.

3. Findings and Results

In this study, the mean and standard deviation of the participants' age in the experimental group were 31.80 (SD = 4.96) years, and in the control group, they were 33.87 (SD = 4.17) years. The use of an independent t-test showed no significant difference in age between the two groups. In the experimental group, there were 12 women and 3 men, while the control group had 10 women and 5 men. The use of the chi-square test (χ^2) showed no significant difference in gender between the two groups.

Table 1

Results of Repeated Measures ANOVA for the Effect of the Independent Variable on Self-Compassion Components

Variable	Effects	Sum of Squares	Error Sum of Squares	F	p	η^2
Self-Kindness	Group Effect	104.54	265.02	11.05	.002	.283
	Time Effect	129.07	173.87	20.79	.001	.426
	Group × Time Interaction	99.62	356.84	7.82	.001	.218
Self-Judgment	Group Effect	196.54	402.62	13.67	.001	.328
	Time Effect	98.82	178.67	15.49	.001	.356

	Group × Time Interaction	49.36	331.11	4.17	.022	.130
Common Humanity	Group Effect	102.40	149.20	19.22	.001	.407
	Time Effect	91.27	226.47	11.28	.002	.287
	Group × Time Interaction	77.27	428.27	5.05	.010	.153
Isolation	Group Effect	243.38	466.36	14.61	.001	.343
	Time Effect	112.07	99.53	31.53	.001	.530
	Group × Time Interaction	136.96	174.44	21.98	.001	.440
Mindfulness	Group Effect	270.40	207.56	36.48	.001	.566
	Time Effect	101.40	161.60	17.57	.001	.386
	Group × Time Interaction	88.80	251.24	9.90	.001	.261
Over-Identification	Group Effect	120.18	347.56	9.68	.004	.257
	Time Effect	93.75	95.33	27.54	.001	.496
	Group × Time Interaction	78.02	186.84	11.69	.001	.295

Table 1 shows that the group × time interaction effect is significant for the self-compassion components: self-kindness ($\eta^2 = .218$, $p = .001$, $F = 7.82$), self-judgment ($\eta^2 = .130$, $p = .022$, $F = 4.17$), common humanity ($\eta^2 = .153$, $p = .010$, $F = 5.05$), isolation ($\eta^2 = .440$, $p = .001$, $F = 21.98$), mindfulness ($\eta^2 = .261$, $p = .001$, $F = 9.90$), and over-identification ($\eta^2 = .295$, $p = .001$, $F = 11.69$). Table 2 presents the Bonferroni post-hoc test results for the self-compassion components and total score in both groups across the three measurement stages.

Table 2

Bonferroni Post-Hoc Test Results for Self-Compassion Components

Variable	Timepoints	Mean Difference	Standard Error	p
Self-Kindness	Pre-test vs. Post-test	-3.17	0.58	.001
	Pre-test vs. Follow-up	-2.93	0.64	.001
	Post-test vs. Follow-up	0.23	0.73	1.00
Self-Judgment	Pre-test vs. Post-test	-2.23	0.57	.002
	Pre-test vs. Follow-up	-2.57	0.65	.001
	Post-test vs. Follow-up	-0.33	0.66	1.00
Common Humanity	Pre-test vs. Post-test	-2.63	0.68	.002
	Pre-test vs. Follow-up	-2.47	0.73	.007
	Post-test vs. Follow-up	0.17	0.72	1.00
Isolation	Pre-test vs. Post-test	-1.77	0.56	.011
	Pre-test vs. Follow-up	-2.73	0.49	.001
	Post-test vs. Follow-up	-0.97	0.27	.004
Mindfulness	Pre-test vs. Post-test	-2.13	0.63	.006
	Pre-test vs. Follow-up	-2.60	0.62	.001
	Post-test vs. Follow-up	-0.47	0.34	.550
Over-Identification	Pre-test vs. Post-test	-1.70	0.55	.013
	Pre-test vs. Follow-up	-2.50	0.48	.001
	Post-test vs. Follow-up	-0.80	0.38	.131

The Bonferroni test results in Table 2 show that the mean differences in the six self-compassion components between the experimental and control groups are statistically significant. Intensive Short-Term Dynamic Psychotherapy (ISTDP) led to an increase in the mean scores of self-compassion components in the post-test and follow-up stages compared to the pre-test stage, whereas no similar changes were observed in the control group during the study period. The trends in mean changes for each self-compassion component, as depicted in the graphs in Figure 1, indicate that the effects of ISTDP on self-compassion components remained stable after the treatment period.

Table 3

Results of Repeated Measures ANOVA for the Effect of the Independent Variable on Defense Mechanisms

Variable	Effects	Sum of Squares	Error Sum of Squares	F	p	η^2
Immature Defense Mechanisms	Group Effect	13690.00	8179.16	46.87	.001	.626
	Time Effect	3375.00	4252.73	22.22	.001	.442
	Group × Time Interaction	4990.07	8056.84	17.34	.001	.382
Mature Defense Mechanisms	Group Effect	1777.78	2529.11	19.68	.001	.413
	Time Effect	589.07	1456.87	11.32	.002	.288
	Group × Time Interaction	585.76	2475.42	6.63	.004	.191
Neurotic Defense Mechanisms	Group Effect	1960.00	4213.82	13.02	.001	.317
	Time Effect	576.60	796.13	20.28	.001	.420
	Group × Time Interaction	338.47	1270.18	7.46	.007	.210

Table 3 shows that the group × time interaction effect is significant for immature defense mechanisms ($\eta^2 = .382$, $p = .001$, $F = 17.34$), mature defense mechanisms ($\eta^2 = .191$, $p = .004$, $F = 6.63$), and neurotic defense mechanisms ($\eta^2 = .210$, $p = .007$, $F = 7.46$). Table 4 presents the Bonferroni post-hoc test results for defense mechanisms across the three stages of the study.

Table 4

Bonferroni Post-Hoc Test Results for Defense Mechanisms

Variable	Timepoints	Mean Difference	Standard Error	p
Immature Defense Mechanisms	Pre-test vs. Post-test	15.57	3.71	.001
	Pre-test vs. Follow-up	15.00	3.18	.001
	Post-test vs. Follow-up	-0.57	2.22	1.00
Mature Defense Mechanisms	Pre-test vs. Post-test	-8.37	1.89	.001
	Pre-test vs. Follow-up	-6.27	1.86	.007
	Post-test vs. Follow-up	2.10	1.34	.386
Neurotic Defense Mechanisms	Pre-test vs. Post-test	6.37	1.54	.001
	Pre-test vs. Follow-up	6.20	1.38	.001
	Post-test vs. Follow-up	-0.17	0.53	1.00

The Bonferroni test results in Table 4 show that the mean differences for immature, mature, and neurotic defense mechanisms between the pre-test and post-test, as well as the pre-test and follow-up stages, are statistically significant. However, the mean differences between the post-test and follow-up stages are not significant. Additionally, the Bonferroni test results comparing group effects show that the mean differences for immature, mature, and neurotic defense mechanisms between the ISTDP and control groups are significant. ISTDP led to an increase in mature defense mechanisms and a decrease in immature and neurotic defense mechanisms in the post-test and follow-up stages.

4. Discussion and Conclusion

The present study's results showed that Intensive Short-Term Dynamic Psychotherapy (ISTDP) increases self-compassion in individuals with depression. This finding aligns with prior findings (Alirezaei et al., 2022).

One explanation for this finding is that a core assumption of ISTDP is that the creation and internal experience of guilt regarding anger lead to improved self-compassion in clients. According to this theory, when clients realize that previous feelings of guilt stemming from their aggressive impulses relate to attachment-related traumas, their self-compassion increases. In ISTDP, adaptive guilt is considered a feeling that motivates efforts to repair the harm caused to others (Frederickson, 2013).

In ISTDP, self-compassion, or its absence, is viewed as a trait or personality variable that largely develops through identification with a punitive caregiver (Frederickson, 2013). Here, identification means that the child sees themselves as the attachment figure perceives them. This identification stems from the child's need to maintain a relationship with the punitive attachment figure but hinders the integration of complex emotions (emotions containing more than one component, such as a combination of fear, anger, and hatred) toward the punitive attachment figures.

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Furthermore, the unconscious guilt about expressing anger toward the attachment figure may result in a need for suffering. Therefore, the experience of complex emotions (such as guilt about anger) should promote emotional integration, gradually replacing any overt or hidden need for self-punishment (Ghorbani, 2019). Thus, in ISTDP, guilt and self-compassion are inherently related constructs, and the lack of self-compassion can largely be seen in relation to the patient's unconscious guilt.

Another explanation for the effectiveness of ISTDP on self-compassion lies in its emphasis on anger, as anger is considered highly significant in ISTDP. In everyday life, feelings of hurt or anger (including those directed at the therapist) may serve as reminders or triggers of mixed feelings (including reactive anger) toward people associated with early attachment, who are unconsciously repressed due to attachment trauma (Town et al., 2021). The goal of ISTDP is to access emotions that have been long suppressed or neglected in the unconscious (Abbass, 2006).

The primary focus of psychodynamic therapy is on emotional or psychological pain, where life is perceived as a challenging and exhausting process. The psyche builds defenses or avoidance mechanisms to cope with this pain—ways of seeing, thinking, feeling, and acting that often occur outside of conscious awareness. These unconscious attempts to avoid emotional pain often fail, but because individuals' awareness is limited, they are repeatedly enacted. Psychodynamic therapy helps clients reformulate their experiences more fully in therapy and tolerate the distress it evokes. The understanding developed between the therapist and client regarding these problems expands the client's awareness and opens up new options for managing conflicts. It also enhances the client's capacity to tolerate emotional pain and dissatisfaction, increasing their ability for self-compassion in relation to their experiences (Johnstone & Dallos, 2006).

The current study's findings also revealed that ISTDP increases the use of mature defense mechanisms while decreasing the use of immature and neurotic defense mechanisms in individuals with depression. This result is consistent with previous studies (Hajloo & Molaei, 2020; Heidari Nasab et al., 2014; Mahboudi et al., 2022; Moazzami Goudarzi et al., 2021).

This finding can be explained by the influence of Freud's second theory of anxiety and Bowlby's attachment theory on ISTDP. According to this therapy approach, early attachment experiences have profound developmental effects, leading to the formation of lasting patterns in adulthood. Emotions and impulses that damage attachment relationships may become unacceptable experiences that manifest in conscious experiences. ISTDP posits that neurotic symptoms like depression can be conceptualized within a conflict triangle. Emotions, as the dependent variable in this study, lie at the center of this conflict triangle. Emotions and impulses that disrupt attachment relationships can serve as sources of anxiety, which the individual avoids using defense mechanisms. Consequently, defense mechanisms protect the individual from complex and unconscious impulses and emotions that might otherwise disrupt attachment relationships. In the long term, avoidance of emotional experiences contributes to the formation of neurotic symptoms and the maintenance of problematic relational patterns (Hoviatdoost et al., 2020).

As integrated internal experiences increase, individuals gain greater capacity to view themselves and others in more complex ways and use coping skills or defenses that distort reality less. The greater organization of internal experiences and cognitive growth also enhances the capacity to tolerate anxiety. Increased anxiety tolerance reduces the need to distort reality and promotes the use of adaptive and effective defense mechanisms. Sometimes individuals rely on primary defense mechanisms due to biological predispositions that exacerbate anxiety, limited capacity to tolerate anxiety, or environments that create severe anxiety and negative affect, requiring these defenses for psychological pain relief. Significant trauma or its repetition can have similar effects. When primary defense mechanisms are adopted as characteristic behaviors to manage anxiety or cope with tension, they increasingly become stable, trait-like behavioral patterns that shape ways of experiencing the world (Huprich, 2015).

In ISTDP, the patient's resistance to emotional experience in the transference is broken using pressure and challenge. Underlying unconscious emotions surface and are experienced, revealing the neurotic structure. The insight and changes resulting from this process link transference experiences with the patient's current and past learning, thereby identifying patterns that have been sources of suffering and symptom formation throughout the patient's life. In summary, the goal of ISTDP is to resolve problematic symptoms and defenses (Huprich, 2015).

ISTDP helps individuals bring unconscious impulses and emotions to conscious awareness, a process known as unconscious decoding. Depending on the complexity and intensity of the emotions experienced, the decoding process can have varying levels. Often, these complex emotions

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develop toward the therapist. Once these emotions emerge, the therapist supports the client in exploring the connection between these emotions and past attachment experiences, leading to a high level of insight, which, in turn, reduces anxiety and empowers the client to change harmful patterns. Since defense mechanisms are used to protect the client from unwanted experiences, varying levels of client resistance may appear. Thus, a level of tension arises between the self-preserving nature of defense mechanisms, the client's unconscious tendencies, and their natural inclination to better understand themselves and be recognized by the therapist (the unconscious desire for a therapeutic alliance). The therapist uses interventions to overcome this resistance but must adjust the intensity of these interventions based on the client's psychological fragility. Clients with psychological fragility are those who lack sufficient adaptive defense mechanisms for self-regulation or to cope with the pressure and challenges arising from exploring unconscious emotions. Such clients are supported in ISTDP to rebuild their defense systems to function more effectively (Hoviatdoost et al., 2020).

5. Limitations & Suggestions

Every study has limitations. In this study, the gender imbalance between men and women makes it impossible to present separate results by gender. Additionally, the study could not include a longer follow-up period (e.g., six months or one year). Future studies should include equal representation of men and women. It is also recommended that future research incorporate a six-month or one-year follow-up period to examine the long-term effects of ISTDP. Offering interventions focused on unhealthy defense mechanisms can raise awareness about ineffective coping strategies and their consequences, such as depression stemming from a lack of self-compassion. Additionally, tailoring therapeutic interventions based on individual personality characteristics, such as personality predispositions and the conditions of each patient, may help patients improve their defense mechanisms and better adapt to their environment.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. The ethical considerations of this study included obtaining informed consent, ensuring privacy and confidentiality. To maintain ethical standards, all participants were assured that the information collected would only be used to present the results in the dissertation and that their data would remain confidential. Additionally, participants were reminded that they could withdraw from the study at any time. To further adhere to ethical principles, the control group received a similar intervention after the study was completed. This dissertation was registered with the code IR.IAU.R.REC.1402.014 in the National Ethics Committee in Biomedical Research at https://ethics.research.ac.ir.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contributed in this article.

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