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The Effectiveness of Emotional Schema Therapy on Defense Mechanisms, Emotional Distress Tolerance, and Psychosomatic Symptoms in Married Women with Psychosomatic Disorder Symptoms

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A B S T R A C T

Objective: This study aimed to examine the effectiveness of emotional schema therapy on defense mechanisms, emotional distress tolerance, and psychosomatic symptoms in married women with symptoms of psychosomatic disorder.

Methods and Materials: This quasi-experimental study used a pretest–posttest design with a control group. The participants were married women with symptoms of psychosomatic disorder in Isfahan. Eligible participants were selected through convenience sampling and randomly assigned to an experimental group and a control group. The experimental group received eight 90-minute sessions of emotional schema therapy, while the control group received no psychological intervention during the study period. Data were collected using the Defense Style Questionnaire-40, the Distress Tolerance Scale, and the Psychosomatic Symptoms Questionnaire. Data were analyzed using multivariate analysis of covariance and follow-up ANCOVA tests.

Findings: The multivariate results showed a significant overall effect of emotional schema therapy on the combined outcomes, Wilks' $\Lambda = .246$, $F(5, 24) = 14.68$, $p = .001$, $\eta^2 = .75$. Follow-up analyses showed significant effects on mature defense, $F(1, 28) = 9.73$, $p = .004$, $\eta^2 = .25$; immature defense, $F(1, 28) = 6.25$, $p = .010$, $\eta^2 = .18$; neurotic defense, $F(1, 28) = 14.90$, $p = .001$, $\eta^2 = .34$; emotional distress tolerance, $F(1, 28) = 32.58$, $p = .001$, $\eta^2 = .53$; and psychosomatic symptoms, $F(1, 28) = 4.54$, $p = .040$, $\eta^2 = .14$.

Conclusion: Emotional schema therapy improved defensive functioning, increased emotional distress tolerance, and reduced psychosomatic symptoms in married women with psychosomatic disorder symptoms. Therefore, it may be considered an effective intervention for improving emotional and somatic functioning in this population.

Keywords: *Emotional schema therapy; Defense mechanisms; Emotional distress tolerance; Psychosomatic symptoms; Married women.*

1. Introduction

Early maladaptive schemas are deep and pervasive cognitive-emotional patterns that develop during childhood and adolescence through adverse experiences, unmet emotional needs, dysfunctional family environments, and maladaptive interpersonal interactions. These schemas shape the way individuals perceive themselves, others, and the world and often persist throughout adulthood, influencing emotional experiences, coping strategies, interpersonal functioning, and psychological adjustment (Namavari et al., 2023; Sharma, 2021). According to schema theory, maladaptive schemas are activated when individuals encounter situations reminiscent of earlier emotional experiences, leading to intense emotional reactions, distorted interpretations, maladaptive coping behaviors, and persistent psychological distress. Schema-based conceptualizations suggest that many emotional and psychosomatic problems emerge not only from current stressors but also from enduring maladaptive beliefs about vulnerability, rejection, shame, emotional deprivation, mistrust, abandonment, and failure (Besharat et al., 2019; Nejadian et al., 2017).

One of the important psychological processes associated with early maladaptive schemas is the use of defense mechanisms. Defense mechanisms are unconscious psychological operations that individuals employ to protect themselves from anxiety, emotional pain, inner conflict, and threatening thoughts or feelings. Although defenses may initially reduce psychological discomfort, persistent reliance on maladaptive defenses can interfere with emotional awareness, adaptive coping, and psychological growth. The relationship between maladaptive schemas and defense mechanisms has received considerable theoretical and empirical attention because schemas often determine the type of defensive strategies individuals use in response to emotional threats (Besharat et al., 2019; Ezatian & Ahmadpanah, 2017). Individuals with maladaptive schemas may use immature defenses such as denial, projection, somatization, repression, dissociation, or avoidance because these defenses temporarily reduce emotional pain while preventing direct processing of distressing emotional experiences.

Research has consistently demonstrated that maladaptive schemas are associated with maladaptive defensive functioning across different psychological and clinical populations. Besharat et al. reported that early maladaptive schemas mediate the relationship between attachment styles and defense mechanisms, indicating that maladaptive schemas influence how individuals regulate emotional conflicts and interpersonal anxieties (Besharat et al., 2019). Similarly, Ezatian and Ahmadpanah found significant relationships between early maladaptive schemas, alexithymia, and ego defensive styles among university students, suggesting that schema-related emotional difficulties may contribute to maladaptive defensive processes (Ezatian & Ahmadpanah, 2017). Nejadian et al. also showed that patients with migraine headaches exhibited significant associations between defensive styles and maladaptive schemas, supporting the role of schema-based emotional processes in psychosomatic conditions (Nejadian et al., 2017).

The relationship between maladaptive schemas and defense mechanisms becomes especially important in psychosomatic and emotional disorders because individuals who experience intense emotional distress may rely on defensive avoidance rather than adaptive emotional processing. Emotional conflicts that remain unresolved may be redirected into bodily symptoms, maladaptive coping strategies, or interpersonal dysfunction. Yousefi et al. demonstrated that maladaptive schemas and defense styles were significantly associated with hoarding behaviors among university students, emphasizing the role of schemas and defenses in maladaptive behavioral patterns (Yousefi et al., 2018). Sharma also reported that individuals with obsessive-compulsive disorder, particularly those with histories of childhood sexual abuse, showed maladaptive schema patterns alongside dysfunctional defense mechanisms and insecure attachment styles (Sharma, 2021). These findings suggest that maladaptive schemas may influence psychopathology partly through maladaptive defensive functioning.

Another central psychological construct associated with maladaptive schemas is distress tolerance. Distress tolerance refers to an individual's perceived and actual ability to endure negative emotional states without becoming overwhelmed, engaging in impulsive behaviors, or relying on maladaptive avoidance strategies. Individuals with low distress tolerance often perceive emotional experiences as intolerable, threatening, uncontrollable, or shameful. Consequently, they may attempt to suppress emotions, avoid distressing experiences, or escape emotional discomfort through maladaptive coping mechanisms. Schema theory suggests that maladaptive schemas intensify emotional vulnerability and reduce emotional resilience because schema activation triggers intense negative affect and

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catastrophic emotional interpretations (Babaeifard et al., 2024; Mohamadi & Jabalameli, 2024).

Low distress tolerance has been associated with emotional dysregulation, self-injurious behaviors, psychosomatic symptoms, interpersonal conflict, and various forms of psychopathology. Babaeifard et al. found that early maladaptive schemas and distress tolerance significantly contributed to self-injury among Iranian adolescents, and transdiagnostic emotional factors mediated these relationships (Babaeifard et al., 2024). Their findings indicate that maladaptive schemas may increase vulnerability to maladaptive emotional coping by weakening individuals' capacity to tolerate emotional pain. Similarly, Mohamadi and Jabalameli demonstrated that group schema therapy significantly improved distress tolerance and reduced self-criticism among women with substance-dependent spouses (Mohamadi & Jabalameli, 2024). These findings support the notion that schema-focused interventions may improve emotional resilience and adaptive coping by modifying maladaptive emotional beliefs and increasing tolerance of distress.

Distress tolerance is also closely related to psychosomatic symptoms because emotional suppression and chronic emotional arousal can contribute to physiological dysregulation. Individuals with low distress tolerance may become highly reactive to emotional experiences and bodily sensations, leading to increased somatic focus, health anxiety, and psychosomatic complaints. Chronic emotional avoidance may maintain activation of stress-related physiological systems and contribute to symptoms such as headaches, gastrointestinal problems, cardiovascular discomfort, fatigue, muscle pain, and other bodily complaints. Mobarhan and Foroutan-Bagha showed that early maladaptive schemas significantly predicted psychosomatic symptoms among working women, emphasizing the important role of schema-based emotional processes in somatic distress (Mobarhan & Foroutan-Bagha, 2024). These findings are consistent with biopsychosocial perspectives suggesting that maladaptive emotional processing contributes substantially to psychosomatic symptom formation.

Women may be especially vulnerable to emotional distress and psychosomatic symptoms because they often experience multiple interpersonal, social, familial, and caregiving pressures simultaneously. Married women may encounter chronic emotional demands associated with marital roles, parenting responsibilities, emotional labor, and social expectations. In many cultural contexts, women may also be encouraged to suppress negative emotions such as anger, disappointment, sadness, or frustration in order to preserve family harmony or maintain interpersonal relationships. Persistent emotional suppression and invalidation may contribute to schema activation, maladaptive defenses, emotional dysregulation, and psychosomatic distress (Bahrami et al., 2025; Mobarhan & Foroutan-Bagha, 2024). Therefore, interventions targeting emotional schemas and maladaptive coping mechanisms may be particularly beneficial for women experiencing psychosomatic symptoms and emotional distress.

Schema therapy has emerged as one of the most influential integrative approaches for addressing chronic emotional and personality-related difficulties. Schema therapy combines elements of cognitive-behavioral therapy, attachment theory, psychodynamic approaches, emotion-focused interventions, and experiential techniques to modify maladaptive schemas and strengthen adaptive functioning. Schema-focused interventions attempt to identify dysfunctional emotional patterns, challenge maladaptive beliefs, heal unmet emotional needs, and improve adaptive coping and emotional regulation (Assmann et al., 2024; Kopf-Beck et al., 2024). Recent empirical evidence has supported the effectiveness of schema therapy across a variety of psychological disorders and emotional difficulties.

Kopf-Beck et al. compared schema therapy, cognitive behavioral therapy, and supportive therapy for depression and found that schema therapy produced significant improvements in depressive symptoms and emotional functioning in inpatient and day-clinic settings (Kopf-Beck et al., 2024). Assmann et al. also reported that schema therapy was highly effective in treating borderline personality disorder and produced meaningful improvements comparable to dialectical behavior therapy (Assmann et al., 2024). These findings support the clinical utility of schema-focused interventions for disorders involving emotional dysregulation, maladaptive coping, and chronic psychological distress.

Schema therapy has also shown promising outcomes in improving emotional regulation, distress tolerance, interpersonal functioning, and maladaptive coping strategies. Khayabani demonstrated that emotional schema therapy improved emotion regulation strategies, distress tolerance, social problem solving, and reduced risky behaviors among adolescent boys (Khayabani, 2024). Zareei et al. compared mindfulness-based cognitive therapy and schema therapy among women with obsessive-compulsive symptoms and found significant improvements in emotion

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regulation and distress intolerance following schema-based interventions (Zareei et al., 2024). These studies suggest that schema-oriented interventions may improve emotional resilience by modifying maladaptive emotional beliefs and increasing adaptive emotional processing.

The effectiveness of schema therapy may partly stem from its emphasis on emotional experiences rather than merely symptom reduction. Traditional cognitive approaches often focus primarily on distorted thoughts and behaviors, whereas schema therapy also addresses deeper emotional vulnerabilities rooted in childhood experiences and unmet emotional needs. Through cognitive restructuring, experiential exercises, imagery rescripting, emotional processing, limited reparenting, and behavioral pattern-breaking techniques, schema therapy helps individuals reinterpret emotional experiences and respond to them more adaptively (Assmann et al., 2024; Kopf-Beck et al., 2024). This deeper emotional focus may explain why schema-focused approaches are effective in improving distress tolerance and defensive functioning.

Emotional schema therapy, a schema-oriented approach emphasizing beliefs and interpretations about emotions, may be particularly relevant for psychosomatic symptoms and emotional distress. Individuals with maladaptive emotional schemas often believe that emotions are uncontrollable, dangerous, shameful, invalid, or intolerable. Such beliefs may increase emotional suppression, avoidance, rumination, maladaptive defenses, and psychosomatic manifestations. Emotional schema interventions aim to normalize emotions, reduce fear and shame regarding emotional experiences, increase emotional acceptance, and strengthen adaptive coping responses (Khayabani, 2024; Zareei et al., 2024). Through this process, individuals may become more capable of tolerating distress without resorting to maladaptive defensive or psychosomatic responses.

Research has increasingly supported the role of schema-based interventions in reducing psychological distress and improving adaptive functioning. Fereydooni and Sheykhan found that schema therapy significantly reduced depression and improved self-esteem and distress tolerance among fatherless depressed adolescents (Fereydooni & Sheykhan, 2024). Zerang et al. also reported that schema therapy significantly reduced psychological distress and improved life engagement among couples experiencing marital conflict (Zerang et al., 2025). Bahrami et al. further demonstrated that early maladaptive schemas significantly predicted psychological distress among women with domestic violence experiences (Bahrami et al., 2025). Collectively, these findings suggest that maladaptive schemas are deeply involved in emotional suffering and that schema-based interventions may effectively improve emotional adjustment.

In addition, schema-focused approaches may reduce psychosomatic symptoms by helping individuals establish healthier relationships with emotions and bodily experiences. When individuals become capable of recognizing, tolerating, and expressing emotions adaptively, physiological arousal associated with chronic emotional suppression may decrease. Emotional awareness and adaptive emotional processing may weaken the cycle connecting emotional distress, maladaptive defenses, and bodily symptoms. Because psychosomatic symptoms are often maintained through emotional avoidance and chronic stress activation, schema-focused emotional interventions may provide clinically meaningful improvements in both psychological and somatic functioning (Babaeifard et al., 2024; Mobarhan & Foroutan-Bagha, 2024).

Despite growing evidence supporting schema-based interventions, relatively limited research has simultaneously examined defense mechanisms, distress tolerance, and psychosomatic symptoms within a unified schema-oriented framework, particularly among married women experiencing psychosomatic distress. Most previous studies have focused on either emotional regulation, depression, personality disorders, or specific behavioral outcomes independently. Moreover, the role of emotional schema interventions in improving defensive functioning and psychosomatic symptoms among married women remains insufficiently explored. Considering the central role of maladaptive schemas in emotional distress, maladaptive defenses, and psychosomatic functioning, further investigation of schema-focused interventions appears necessary.

Given the theoretical and empirical relationships among maladaptive schemas, defense mechanisms, distress tolerance, and psychosomatic symptoms, emotional schema therapy may provide an effective intervention for improving emotional and somatic functioning in married women experiencing psychosomatic distress. By modifying dysfunctional emotional beliefs, reducing maladaptive defensive avoidance, increasing emotional awareness, and strengthening distress tolerance, emotional schema therapy may help individuals process emotions more adaptively and reduce psychosomatic symptom expression. Therefore, the present study aimed to examine the effectiveness of emotional schema therapy on defense mechanisms,

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emotional distress tolerance, and psychosomatic symptoms in married women with psychosomatic disorder symptoms.

2. Methods and Materials

2.1. Study design and Participant

The present study used a quasi-experimental design with a pretest–posttest control group. The independent variable was emotional schema therapy, and the dependent variables were defense mechanisms, emotional distress tolerance, and psychosomatic symptoms. Participants were assigned to two groups: an experimental group and a control group. The experimental group received emotional schema therapy, whereas the control group received no psychological intervention during the study period. Both groups completed the study measures at pretest and posttest. This design made it possible to examine the effectiveness of the intervention by comparing posttest scores between the two groups while controlling for baseline differences.

The statistical population consisted of married women with symptoms of psychosomatic disorder who referred to counseling and psychology centers in Isfahan during the study period. After initial screening, eligible participants were selected and assigned to the experimental and control groups. The sample size was determined based on the quasi-experimental design and similar intervention studies, with at least 15 participants considered for each group. Participants who met the inclusion criteria were randomly assigned to either the experimental group or the control group.

The target population was selected because married women with psychosomatic symptoms may experience emotional distress, unresolved psychological conflicts, maladaptive defense mechanisms, and reduced capacity to tolerate emotional distress. These factors may contribute to the persistence or intensification of psychosomatic symptoms. Therefore, this group was considered clinically appropriate for examining the effects of emotional schema therapy on psychological and somatic outcomes.

The main inclusion criteria were being a married woman, having symptoms of psychosomatic disorder, willingness to participate in the study, and ability to complete the questionnaires at pretest and posttest. Participants also had to be available to attend the emotional schema therapy sessions regularly.

The exclusion criteria included unwillingness to continue participation, absence from intervention sessions, incomplete questionnaire responses, and participation in another psychological intervention during the study period. Participants who did not complete the assessment process or who failed to attend the intervention sessions regularly were excluded from the final analysis.

After obtaining the required permissions and coordinating with counseling and psychology centers, eligible participants were identified. The purpose of the study, the voluntary nature of participation, and the confidentiality of information were explained to the participants. After informed consent was obtained, participants completed the pretest measures, including the Defense Style Questionnaire, the Distress Tolerance Scale, and the Psychosomatic Symptoms Questionnaire.

Participants were then assigned to the experimental and control groups. The experimental group received eight 90-minute sessions of emotional schema therapy. The control group did not receive any psychological intervention during the same period. After completion of the intervention, both groups completed the posttest measures under similar conditions. The collected data were then prepared for statistical analysis.

2.2. Measures

Data were collected using standardized questionnaires measuring defense mechanisms, emotional distress tolerance, and psychosomatic symptoms. In the present study, defense mechanisms were operationally defined as participants' scores on the Defense Style Questionnaire, emotional distress tolerance as participants' scores on the Distress Tolerance Scale, and psychosomatic symptoms as participants' scores on the Psychosomatic Symptoms Questionnaire.

Defense mechanisms were measured using the Defense Style Questionnaire-40 developed by Andrews et al. (1993). This questionnaire assesses 20 defense mechanisms and classifies them into three broad styles: mature, immature, and neurotic defenses. The instrument is scored on a Likert scale, and respondents indicate their level of agreement with each item. The questionnaire has been evaluated in several countries and has shown acceptable validity and reliability. In Iran, the questionnaire was standardized by Heidarinasab, and evidence supported its content validity, concurrent validity, construct validity, and overall psychometric adequacy.

Emotional distress tolerance was measured using the Distress Tolerance Scale developed by Simons and Gaher (2005). This self-report instrument includes 15 items and assesses four components of distress tolerance: tolerance,

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absorption, appraisal, and regulation. The tolerance component is measured by items 1, 3, and 5; absorption by items 2, 4, and 15; appraisal by items 6, 7, 9, 10, 11, and 12; and regulation by items 8, 13, and 14. Items are scored on a five-point Likert scale, and higher scores indicate greater distress tolerance. Item 6 is reverse scored. Simons and Gaher reported acceptable internal consistency for the total scale, and Iranian research also reported acceptable reliability for the total score.

Psychosomatic symptoms were measured using the Psychosomatic Symptoms Questionnaire developed by Lacourt et al. (2013). This instrument includes 39 items and is scored on a five-point Likert scale. The questionnaire assesses psychosomatic symptoms such as dizziness, unreality experiences, and other bodily complaints associated with psychological distress. The total score ranges from 39 to 195, with higher scores indicating greater psychosomatic symptom severity. In Iran, the questionnaire was validated by Heidari et al. (2021), and its content, face, and criterion validity were reported as acceptable. Cronbach's alpha for the questionnaire was reported to be above .70.

2.3. Intervention

The experimental group received emotional schema therapy based on Leahy's emotional schema therapy model and the emotion regulation techniques presented by Leahy and colleagues. The intervention consisted of eight 90-minute sessions. The protocol was designed to identify maladaptive emotional schemas, modify dysfunctional beliefs about emotions, reduce emotional avoidance, and improve acceptance and regulation of emotional experiences.

The first session focused on introducing the therapist and group members, explaining the structure and rules of the group, allowing members to express their feelings about participation in the treatment process, and administering the pretest. The second session provided psychoeducation about emotions, introduced the general principles of emotional schema therapy, and explained the rationale and stages of the intervention. The third session focused on defining emotional schemas and examining their effects on feelings and behaviors through examples. The fourth session addressed maladaptive emotion regulation strategies and introduced adaptive alternatives.

In the remaining sessions, participants were guided to identify dysfunctional beliefs about emotions, challenge beliefs such as "emotions are unbearable," "emotional expression is shameful," or "negative emotions will last forever," and replace them with more adaptive emotional beliefs. The sessions also emphasized increasing emotional awareness, reducing suppression and rumination, strengthening tolerance of negative emotions, and applying healthier strategies for managing distress. The final session focused on reviewing therapeutic gains, consolidating adaptive emotional schemas, and preparing participants to maintain changes after the intervention.

2.4. Data Analysis

Data were analyzed using descriptive and inferential statistics. Descriptive statistics, including mean and standard deviation, were used to summarize the scores of defense mechanisms, emotional distress tolerance, and psychosomatic symptoms in the experimental and control groups. Before conducting the main analyses, the assumptions of parametric analysis were examined. Normality of the variables, homogeneity of variances, homogeneity of regression slopes, and equality of covariance matrices were assessed.

To examine the effectiveness of emotional schema therapy on defense mechanisms, emotional distress tolerance, and psychosomatic symptoms, multivariate analysis of covariance was used. Follow-up analyses were conducted to examine the intervention effects on each dependent variable separately. In addition, because emotional distress tolerance included four components—tolerance, absorption, appraisal, and regulation—multivariate analysis of covariance was also used to examine the intervention effect on these components. The significance level was set at .05.

3. Findings and Results

The participants were married women with symptoms of psychosomatic disorder who were assigned to an experimental group and a control group. The experimental group received emotional schema therapy, whereas the control group received no psychological intervention during the study period. The main study variables included defense mechanisms, emotional distress tolerance, and psychosomatic symptoms. In addition, the components of emotional distress tolerance, including emotional tolerance, emotional absorption, negative appraisal of distress, and regulation, were examined separately.

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Before conducting the main analyses, the assumptions of multivariate analysis of covariance were examined. The Kolmogorov–Smirnov test showed that the distributions of mature defense, immature defense, neurotic defense, emotional distress tolerance, and psychosomatic symptoms were normal at both pretest and posttest. All significance values were greater than .05; therefore, the normality assumption was supported. In addition, Levene's test was used to examine the homogeneity of error variances, and the homogeneity of regression slopes was also tested. The results indicated that the interaction between group and the covariate was not significant for the study variables, supporting the assumption of homogeneous regression slopes. Therefore, the data met the necessary assumptions for covariance analysis.

Table 1 presents the means and standard deviations of defense mechanisms, emotional distress tolerance, and psychosomatic symptoms in the experimental and control groups at pretest and posttest. As shown, the experimental group showed an increase in mature defense mechanisms and emotional distress tolerance after the intervention. In contrast, immature and neurotic defense mechanisms, as well as psychosomatic symptoms, decreased in the experimental group. The control group showed only minor changes across the two measurement stages.

Table 1

Means and Standard Deviations of Defense Mechanisms, Emotional Distress Tolerance, and Psychosomatic Symptoms by Group and Time

Variable	Time	Experimental M	Experimental SD	Control M	Control SD
Mature defense	Pretest	33.00	7.88	34.60	6.71
Mature defense	Posttest	45.93	6.29	36.40	7.32
Immature defense	Pretest	138.60	21.18	135.47	18.65
Immature defense	Posttest	111.47	25.18	131.73	18.73
Neurotic defense	Pretest	40.67	10.63	42.20	9.57
Neurotic defense	Posttest	27.13	9.50	40.20	9.03
Emotional distress tolerance	Pretest	29.53	8.59	31.00	4.53
Emotional distress tolerance	Posttest	43.00	5.38	32.33	4.83
Psychosomatic symptoms	Pretest	107.20	26.53	109.93	14.95
Psychosomatic symptoms	Posttest	92.53	22.05	107.20	14.95

The descriptive findings indicate that emotional schema therapy was associated with improvement in adaptive psychological functioning. Mature defense increased from 33.00 to 45.93 in the experimental group, while immature defense decreased from 138.60 to 111.47 and neurotic defense decreased from 40.67 to 27.13. Emotional distress tolerance increased from 29.53 to 43.00, and psychosomatic symptoms decreased from 107.20 to 92.53. The control group did not show comparable changes. Table 2 presents the descriptive statistics for the components of emotional distress tolerance. The experimental group showed increases in all four components from pretest to posttest, while the control group showed only slight changes.

Table 2

Means and Standard Deviations of Emotional Distress Tolerance Components by Group and Time

Component	Time	Experimental M	Experimental SD	Control M	Control SD
Emotional tolerance	Pretest	4.33	2.32	5.20	2.07
Emotional tolerance	Posttest	8.47	1.76	5.73	2.37
Emotional absorption	Pretest	6.33	2.79	5.93	2.01
Emotional absorption	Posttest	9.13	3.24	6.27	2.18
Negative appraisal of distress	Pretest	13.07	4.78	14.40	3.01
Negative appraisal of distress	Posttest	18.40	3.22	14.67	2.79
Regulation	Pretest	5.80	2.39	5.47	2.06
Regulation	Posttest	7.00	2.75	5.67	2.25
Total distress tolerance	Pretest	29.53	8.59	31.00	4.53
Total distress tolerance	Posttest	43.00	5.38	32.33	4.83

The largest descriptive changes in the experimental group were observed in negative appraisal of distress and emotional tolerance. The mean score for negative appraisal increased from 13.07 to 18.40, and emotional tolerance

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increased from 4.33 to 8.47. Emotional absorption also increased from 6.33 to 9.13. The regulation component increased from 5.80 to 7.00, although this change was smaller than the changes observed in the other components. A multivariate analysis of covariance was conducted to examine the effectiveness of emotional schema therapy on defense mechanisms, emotional distress tolerance, and psychosomatic symptoms. The multivariate results showed a significant overall effect of group, Wilks' $\Lambda = .246$, $F(5, 24) = 14.68$, $p = .001$, $\eta^2 = .75$. Pillai's Trace, Hotelling's Trace, and Roy's Largest Root also indicated significant group differences. This finding shows that, after controlling for pretest scores, the experimental and control groups differed significantly in the combined posttest scores of defense mechanisms, emotional distress tolerance, and psychosomatic symptoms.

Table 3

Multivariate Analysis of Covariance for Main Study Variables

Test	Value	F	Hypothesis df	Error df	p	η^2	Power
Pillai's Trace	.754	14.68	5	24	.001	.75	1.00
Wilks' Lambda	.246	14.68	5	24	.001	.75	1.00
Hotelling's Trace	3.06	14.68	5	24	.001	.75	1.00
Roy's Largest Root	3.06	14.68	5	24	.001	.75	1.00

Follow-up univariate analyses showed that emotional schema therapy significantly affected all main outcome variables. The effect was significant for mature defense, $F(1, 28) = 9.73$, $p = .004$, $\eta^2 = .25$; immature defense, $F(1, 28) = 6.25$, $p = .010$, $\eta^2 = .18$; neurotic defense, $F(1, 28) = 14.90$, $p = .001$, $\eta^2 = .34$; emotional distress tolerance, $F(1, 28) = 32.58$, $p = .001$, $\eta^2 = .53$; and psychosomatic symptoms, $F(1, 28) = 4.54$, $p = .040$, $\eta^2 = .14$. These findings indicate that emotional schema therapy increased mature defense and distress tolerance while reducing immature defense, neurotic defense, and psychosomatic symptoms.

Table 4

Follow-up ANCOVA Results for Defense Mechanisms, Emotional Distress Tolerance, and Psychosomatic Symptoms

Variable	SS	df	MS	F	p	η^2	Power
Mature defense	681.63	1	681.63	9.73	.004	.25	.85
Immature defense	3080.53	1	3080.53	6.25	.010	.18	.67
Neurotic defense	1280.53	1	1280.53	14.90	.001	.34	.96
Emotional distress tolerance	853.33	1	853.33	32.58	.001	.53	.99
Psychosomatic symptoms	1613.33	1	1613.33	4.54	.040	.14	.53

The effect sizes showed that emotional schema therapy explained 25% of the variance in mature defense, 18% of the variance in immature defense, 34% of the variance in neurotic defense, 53% of the variance in emotional distress tolerance, and 14% of the variance in psychosomatic symptoms. Therefore, the strongest effect was observed for emotional distress tolerance, followed by neurotic defense, mature defense, immature defense, and psychosomatic symptoms. A separate multivariate analysis of covariance was conducted for the components of emotional distress tolerance. The multivariate results were significant, Wilks' $\Lambda = .438$, $F(4, 25) = 8.02$, $p = .001$, $\eta^2 = .56$. This result indicates that emotional schema therapy had a significant overall effect on the combined components of emotional distress tolerance.

Table 5

Multivariate Analysis of Covariance for Emotional Distress Tolerance Components

Test	Value	F	Hypothesis df	Error df	p	η^2	Power
Pillai's Trace	.562	8.02	4	25	.001	.56	.99
Wilks' Lambda	.438	8.02	4	25	.001	.56	.99
Hotelling's Trace	1.283	8.02	4	25	.001	.56	.99
Roy's Largest Root	1.283	8.02	4	25	.001	.56	.99

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Follow-up analyses showed that emotional schema therapy had significant effects on emotional tolerance, $F(1, 28) = 12.79$, $p = .001$, $\eta^2 = .31$; emotional absorption, $F(1, 28) = 8.03$, $p = .008$, $\eta^2 = .22$; and negative appraisal of distress, $F(1, 28) = 11.48$, $p = .002$, $\eta^2 = .29$. However, the effect on the regulation component was not statistically significant, $F(1, 28) = 2.10$, $p = .158$, $\eta^2 = .07$.

Table 6

Follow-up ANCOVA Results for Components of Emotional Distress Tolerance

Component	SS	df	MS	F	p	η^2	Power
Emotional tolerance	56.03	1	56.03	12.79	.001	.31	.93
Emotional absorption	61.63	1	61.63	8.03	.008	.22	.78
Negative appraisal of distress	104.53	1	104.53	11.48	.002	.29	.90
Regulation	13.33	1	13.33	2.10	.158	.07	.28

Overall, the findings showed that emotional schema therapy significantly improved psychological and somatic outcomes in married women with symptoms of psychosomatic disorder. Specifically, the intervention increased mature defense mechanisms and emotional distress tolerance and reduced immature defense mechanisms, neurotic defense mechanisms, and psychosomatic symptoms. At the component level, emotional schema therapy significantly improved emotional tolerance, emotional absorption, and negative appraisal of distress, but its effect on the regulation component was not statistically significant. Therefore, the main hypothesis of the study was supported, and the findings indicate that emotional schema therapy can be considered an effective intervention for improving defensive functioning, increasing distress tolerance, and reducing psychosomatic symptoms in this population.

4. Discussion

The present study aimed to examine the effectiveness of emotional schema therapy on defense mechanisms, emotional distress tolerance, and psychosomatic symptoms in married women with psychosomatic disorder symptoms. The findings demonstrated that emotional schema therapy significantly improved psychological functioning by increasing adaptive defensive functioning and emotional distress tolerance while simultaneously reducing maladaptive defenses and psychosomatic symptoms. These findings support the theoretical assumptions underlying schema-based emotional interventions and indicate that emotional schema therapy can effectively target core emotional and cognitive processes associated with psychosomatic distress. The results suggest that modifying maladaptive emotional beliefs and increasing emotional acceptance may improve both psychological and somatic functioning in women experiencing chronic emotional distress.

One of the central findings of the study was the significant improvement in defense mechanisms following emotional schema therapy. Specifically, the intervention increased mature defenses while reducing immature and neurotic defenses. This finding is consistent with schema theory, which proposes that maladaptive schemas strongly influence individuals' emotional reactions and coping strategies. Individuals who perceive emotions as dangerous, shameful, intolerable, or uncontrollable are more likely to rely on maladaptive defenses such as denial, projection, repression, avoidance, or somatization in order to reduce emotional pain. Emotional schema therapy appears to weaken these maladaptive defensive patterns by helping individuals reinterpret emotional experiences as understandable, manageable, and acceptable rather than threatening or overwhelming (Besharat et al., 2019; Ezatian & Ahmadpanah, 2017).

The improvement in defensive functioning may also be explained through increased emotional awareness and emotional flexibility. Many individuals with psychosomatic symptoms attempt to manage emotional distress indirectly because they lack effective emotional processing strategies. When emotions are repeatedly invalidated or suppressed, maladaptive defenses become dominant methods for managing psychological discomfort. Emotional schema therapy encourages clients to identify emotional experiences, understand the meanings attached to emotions, and challenge dysfunctional emotional assumptions. Through this process, participants may become less dependent on defensive avoidance and more capable of consciously processing emotional distress. Consequently, mature defenses such as emotional awareness, adaptive self-reflection, and constructive emotional expression become

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more accessible, whereas immature and neurotic defenses decrease.

These findings are consistent with previous research demonstrating significant associations between maladaptive schemas and defensive styles. Besharat et al. reported that maladaptive schemas mediate the relationship between attachment styles and defense mechanisms, indicating that maladaptive schemas shape emotional coping and defensive functioning (Besharat et al., 2019). Similarly, Nejadian et al. found strong associations between defensive styles and early maladaptive schemas among patients with migraine headaches, supporting the idea that maladaptive emotional processing contributes to psychosomatic conditions (Nejadian et al., 2017). Ezatian and Ahmadpanah also demonstrated that maladaptive schemas are closely related to ego defensive styles and alexithymia among university students (Ezatian & Ahmadpanah, 2017). The findings of the present study extend this literature by showing that emotional schema therapy can actively modify maladaptive defensive functioning among married women experiencing psychosomatic symptoms.

The reduction of immature defenses may be particularly important in psychosomatic populations because maladaptive defenses often contribute to the maintenance of bodily symptoms. Emotional suppression, denial, avoidance, and somatization may prevent direct emotional processing and redirect psychological distress into physiological expression. Emotional schema therapy appears to reduce this defensive cycle by increasing emotional acceptance and reducing fear of emotional experiences. When individuals learn that emotions are temporary and tolerable rather than dangerous or shameful, they become less likely to rely on maladaptive defenses for emotional regulation. This process may reduce emotional tension and improve psychological adjustment.

Another important finding of the study was the significant increase in emotional distress tolerance following emotional schema therapy. In fact, distress tolerance showed one of the strongest treatment effects among the measured variables. This finding supports the assumption that emotional schema interventions directly influence how individuals interpret and manage emotional experiences. Individuals with low distress tolerance often believe that negative emotions are unbearable, uncontrollable, or harmful. These beliefs intensify emotional arousal and increase emotional avoidance. Emotional schema therapy challenges these dysfunctional beliefs and helps individuals normalize emotional experiences, thereby increasing their capacity to tolerate distress without becoming overwhelmed or engaging in maladaptive coping behaviors (Babaeifard et al., 2024; Mohamadi & Jabalameli, 2024).

The increase in distress tolerance can also be explained through the normalization of emotional experiences. Emotional schema therapy teaches that emotions are universal human experiences that do not necessarily require immediate suppression or elimination. Many individuals with psychosomatic symptoms become highly reactive to emotional discomfort because they interpret distress as evidence of weakness, failure, danger, or loss of control. These interpretations may increase physiological arousal and contribute to psychosomatic complaints. By helping individuals reinterpret emotions as manageable and meaningful experiences, emotional schema therapy reduces catastrophic emotional interpretations and strengthens emotional resilience.

The findings regarding distress tolerance are consistent with previous empirical studies. Babaeifard et al. demonstrated that distress tolerance and maladaptive schemas significantly contributed to self-injury among adolescents and that transdiagnostic emotional factors mediated these relationships (Babaeifard et al., 2024). Mohamadi and Jabalameli similarly reported that schema therapy improved distress tolerance among women with substance-dependent spouses (Mohamadi & Jabalameli, 2024). Khayabani also found that emotional schema therapy improved emotion regulation strategies and distress tolerance while reducing risky behaviors among adolescent boys (Khayabani, 2024). Likewise, Zareei et al. showed that schema therapy significantly improved distress intolerance among women with obsessive-compulsive symptoms (Zareei et al., 2024). The present findings align closely with these studies and further support the role of schema-based interventions in strengthening emotional coping capacities.

The effectiveness of emotional schema therapy on distress tolerance may be especially important for married women because this population frequently experiences chronic interpersonal and emotional stressors. Family responsibilities, caregiving demands, relational pressures, and cultural expectations may increase emotional burdens while simultaneously limiting opportunities for healthy emotional expression. Under such conditions, individuals may become emotionally overwhelmed and develop maladaptive coping patterns. Emotional schema therapy provides women with a structured framework for understanding and validating emotional experiences,

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thereby increasing emotional tolerance and reducing emotional avoidance.

The study also found that emotional schema therapy significantly reduced psychosomatic symptoms. This finding is highly important because psychosomatic symptoms are often resistant to treatment when emotional processes remain unaddressed. Psychosomatic symptoms frequently emerge when unresolved emotional distress is redirected into bodily experiences. Chronic emotional suppression, maladaptive emotional beliefs, physiological hyperarousal, and low distress tolerance may all contribute to the persistence of somatic complaints. Emotional schema therapy appears to reduce psychosomatic symptoms by addressing these underlying emotional mechanisms rather than focusing solely on symptom reduction (Bahrami et al., 2025; Mobarhan & Foroutan-Bagha, 2024).

One explanation for the reduction in psychosomatic symptoms is that emotional schema therapy decreases chronic physiological arousal associated with emotional suppression and defensive avoidance. Individuals who consistently avoid emotions may maintain prolonged activation of stress-related physiological systems, including autonomic and endocrine stress responses. Over time, this chronic physiological activation may contribute to fatigue, pain, gastrointestinal complaints, cardiovascular symptoms, and other psychosomatic manifestations. By helping individuals process emotions more openly and adaptively, emotional schema therapy may reduce chronic stress activation and weaken the connection between emotional distress and bodily symptoms.

Another explanation involves the reduction of somatization as a defensive coping mechanism. Individuals who lack emotional awareness or fear emotional expression may communicate distress through bodily symptoms rather than through direct emotional processing. Emotional schema therapy increases emotional awareness and emotional language, helping clients recognize and verbalize emotional experiences that were previously expressed somatically. As emotional awareness improves, there may be less need for psychological distress to manifest through physical symptoms. This mechanism may explain why participants in the intervention group showed reduced psychosomatic symptom severity after treatment.

The findings regarding psychosomatic symptoms are consistent with previous studies emphasizing the role of maladaptive schemas in emotional and somatic distress. Mobarhan and Foroutan-Bagha reported that maladaptive schemas significantly predicted psychosomatic symptoms among working women (Mobarhan & Foroutan-Bagha, 2024). Bahrami et al. also found strong associations between maladaptive schemas and psychological distress among women with domestic violence experiences (Bahrami et al., 2025). These studies support the idea that maladaptive emotional schemas contribute substantially to emotional suffering and bodily distress. The present study extends this literature by demonstrating that emotional schema therapy can effectively reduce psychosomatic symptoms through modification of maladaptive emotional beliefs and coping strategies.

The findings also align with broader evidence supporting the effectiveness of schema-focused interventions across diverse psychological conditions. Kopf-Beck et al. found that schema therapy significantly improved depressive symptoms and emotional functioning in clinical settings (Kopf-Beck et al., 2024). Assmann et al. similarly demonstrated the effectiveness of schema therapy for borderline personality disorder (Assmann et al., 2024). Fereydooni and Sheykhan also reported improvements in depression, self-esteem, and distress tolerance among adolescents receiving schema therapy (Fereydooni & Sheykhan, 2024). Zerang et al. further found that schema therapy reduced psychological distress and improved life engagement among couples experiencing marital conflict (Zerang et al., 2025). Collectively, these findings suggest that schema-focused approaches effectively target deep emotional vulnerabilities underlying many forms of psychological distress.

The present findings are theoretically important because they highlight the interconnected nature of maladaptive schemas, defensive functioning, emotional distress tolerance, and psychosomatic symptoms. Rather than viewing psychosomatic symptoms as isolated bodily complaints, the findings support a broader emotional-processing framework in which maladaptive emotional beliefs contribute to defensive avoidance, emotional intolerance, physiological arousal, and somatic distress. Emotional schema therapy appears to interrupt this cycle by helping individuals reinterpret emotions more adaptively and respond to emotional experiences with greater acceptance and flexibility.

In addition, the findings emphasize the clinical relevance of emotional schema therapy for married women experiencing psychosomatic distress. This population may face unique emotional burdens associated with relational expectations, caregiving demands, emotional labor, and social pressures. Emotional schema therapy provides an

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intervention that directly addresses emotional invalidation, maladaptive coping, and emotional suppression. By increasing emotional acceptance and adaptive emotional processing, the intervention may improve both psychological wellbeing and physical health outcomes in this population.

5. Conclusion

Overall, the findings of the present study indicate that emotional schema therapy is an effective intervention for improving defense mechanisms, increasing emotional distress tolerance, and reducing psychosomatic symptoms among married women with psychosomatic disorder symptoms. The intervention appears to work by modifying maladaptive emotional schemas, increasing emotional awareness, reducing defensive avoidance, strengthening emotional acceptance, and promoting healthier emotional processing. Therefore, emotional schema therapy may be considered a clinically valuable approach for addressing emotional and psychosomatic difficulties simultaneously.

6. Limitations and Suggestions

The present study had several limitations that should be considered when interpreting the findings. First, the sample size was relatively limited, which may reduce the generalizability of the results to broader populations. Second, the participants consisted only of married women with psychosomatic disorder symptoms, and therefore the findings may not generalize to men, unmarried individuals, adolescents, or other clinical groups. Third, the study relied primarily on self-report questionnaires, which may be influenced by response bias, social desirability, or subjective interpretation of emotional experiences. Fourth, the study used a pretest-posttest design without a long-term follow-up assessment; therefore, the stability and durability of the intervention effects over time remain unclear. Finally, the absence of an active comparison treatment group limits conclusions regarding the comparative superiority of emotional schema therapy relative to other psychological interventions.

Future studies are recommended to examine the effectiveness of emotional schema therapy using larger and more diverse samples across different demographic and clinical populations. Researchers should also conduct randomized controlled trials with long-term follow-up assessments to evaluate the durability of treatment effects over time. Comparing emotional schema therapy with other evidence-based interventions such as cognitive behavioral therapy, acceptance and commitment therapy, dialectical behavior therapy, and mindfulness-based interventions may help clarify the unique therapeutic mechanisms of schema-focused approaches. Future research may additionally investigate mediating variables such as emotional awareness, emotional acceptance, attachment styles, emotion regulation strategies, and interpersonal functioning in order to better understand how emotional schema therapy produces psychological and somatic improvements. Examining physiological indicators of stress and psychosomatic functioning alongside self-report measures may also provide a more comprehensive understanding of treatment outcomes.

The findings of the present study suggest that emotional schema therapy may be effectively incorporated into counseling centers, psychosomatic clinics, and mental health treatment programs for women experiencing psychosomatic symptoms and emotional distress. Therapists working with psychosomatic populations should pay greater attention to maladaptive emotional beliefs, emotional suppression, defensive functioning, and low distress tolerance rather than focusing solely on physical symptoms. Psychoeducational programs aimed at increasing emotional awareness and emotional acceptance may help individuals better understand the relationship between emotions and bodily symptoms. In addition, clinicians may benefit from integrating schema-focused emotional interventions into broader psychosomatic treatment programs in order to address deeper emotional vulnerabilities underlying chronic somatic complaints. Finally, mental health professionals should consider the unique emotional pressures experienced by married women and provide supportive interventions that strengthen adaptive emotional coping and emotional resilience.

Authors' Contributions

Authors equally contributed to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

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

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Declaration of Interest

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Ethical Considerations

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