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A Comparison of a Psychodynamic Emotion-Focused Therapy Package with Dialectical Behavior Therapy: Emphasizing the Reduction of Aggression and Rumination in Women with Comorbid Depression and Social Anxiety

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A B S T R A C T

Objective: This study aimed to compare the effectiveness of a psychodynamic emotion-focused therapy package and dialectical behavior therapy in reducing aggression and rumination among women with comorbid depression and social anxiety.

Methods and Materials: The study employed a mixed-methods qualitative-quantitative design. In the qualitative phase, the components of the psychodynamic emotion-focused therapy package were developed through deductive thematic analysis. In the quantitative phase, a quasi-experimental pretest-posttest design with a two-month follow-up and a control group was implemented. The statistical population comprised single women aged 20–40 years with comorbid depression and social anxiety who were referred to counseling centers in Isfahan, Iran. A total of 45 eligible participants were selected through purposive sampling and randomly assigned to psychodynamic emotion-focused therapy, dialectical behavior therapy, and control groups. Data were collected using the Beck Depression Inventory, Connor Social Anxiety Inventory, Rumination Response Scale, and Eysenck and Glenn Wilson Aggression Questionnaire. Repeated-measures analysis of variance and Bonferroni post-hoc comparisons were used for inferential analysis.

Findings: Repeated-measures analysis revealed significant time-by-group effects for rumination, indicating that both psychodynamic emotion-focused therapy and dialectical behavior therapy significantly reduced rumination compared with the control condition, with treatment effects maintained at the two-month follow-up ($p < .001$). For aggression, significant between-group differences were observed, with psychodynamic emotion-focused therapy producing a significantly greater reduction than both dialectical behavior therapy and the control condition ($p < .001$). Dialectical behavior therapy did not significantly differ from the control group in reducing aggression.

Conclusion: Both psychodynamic emotion-focused therapy and dialectical behavior therapy appear effective for reducing rumination in women with comorbid depression

and social anxiety. However, psychodynamic emotion-focused therapy demonstrates superior efficacy for aggression, suggesting that its emphasis on deeper emotional processing and underlying intrapsychic conflicts may provide additional therapeutic benefits when aggression constitutes a prominent clinical symptom.

Keywords: *Aggression, Comorbid Depression, Dialectical Behavior Therapy, Psychodynamic Emotion-Focused Therapy, Rumination, Social Anxiety*

1. Introduction

Depression and social anxiety are among the most prevalent and disabling emotional disorders and frequently occur together, producing a clinical profile that is generally more persistent and complex than either disorder alone. Depression is characterized by sustained low mood, loss of interest or pleasure, cognitive distortions, reduced motivation, hopelessness, and a range of behavioral and somatic disturbances, while social anxiety is distinguished by marked fear of social scrutiny, negative evaluation, embarrassment, and avoidance of interpersonal or performance situations. When these disorders coexist, their symptoms may interact in a mutually reinforcing manner: fear of social judgment can increase withdrawal and isolation, while depressive cognition may intensify expectations of rejection and failure. Evidence from population-based research suggests that mood and anxiety disorders share a number of vulnerability factors and that comorbidity is not merely the coincidental presence of two conditions but may represent the convergence of overlapping psychosocial and emotional mechanisms (Hassan & Feng, 2026). Clinical studies have similarly emphasized that social anxiety disorder commonly co-occurs with depressive disorders and that this pattern of comorbidity creates important diagnostic and therapeutic challenges because it is associated with increased symptom severity, chronicity, functional impairment, and poorer treatment response (Koyuncu et al., 2019). Depression itself also remains associated with significant cognitive, affective, and functional impairment across different clinical populations, highlighting the necessity of interventions that address not only overt symptoms but also the processes that sustain emotional disorders (Christensen et al., 2023). Accordingly, the treatment of individuals with concurrent depression and social anxiety requires consideration of shared transdiagnostic mechanisms rather than exclusive attention to isolated diagnostic symptoms.

Among the psychological processes that may contribute to the persistence of depression and social anxiety, rumination has received substantial attention. Rumination refers to repetitive, passive, and recurrent thinking about negative emotions, distress, their possible causes, and their consequences without effective movement toward problem solving or behavioral change. Rather than facilitating emotional resolution, persistent rumination tends to prolong negative affect, reinforce dysfunctional beliefs, maintain attentional bias toward threat or failure, and interfere with adaptive coping. A comprehensive examination of rumination has indicated that it functions as both a consequence and a maintaining mechanism of emotional distress, with important implications for depression and anxiety treatment (Watkins & Roberts, 2020). Rumination may be especially problematic among individuals with social anxiety because repeated post-event processing, self-focused attention, and mental review of perceived social failures can strengthen negative self-evaluation and anticipatory anxiety. Research has also demonstrated that anger rumination, aggression, and maladaptive problem-solving styles can meaningfully predict social anxiety, suggesting that repetitive cognition and behavioral dysregulation may be interconnected within the social anxiety process (Farajinia et al., 2020). Similarly, interventions targeting maladaptive cognitive and emotional processing have demonstrated reductions in rumination among individuals with anxiety-related problems, further supporting rumination as an important therapeutic target (Sharif Ara et al., 2023). Thus, reducing rumination may be central to disrupting the cognitive-affective cycle through which depression and social anxiety reinforce one another.

Aggression represents another clinically relevant behavioral and emotional outcome associated with difficulties in affect regulation. Aggression can manifest directly through verbal or physical behavior or indirectly through hostility, irritability, anger, interpersonal conflict, and maladaptive reactions to perceived threat. Although aggression is not a defining symptom of either depression or social anxiety, research increasingly indicates that negative affect, threat sensitivity, emotional dysregulation, and hostile interpretations may contribute to aggressive responding in individuals experiencing internalizing symptoms. The reciprocal relationship among depression, social anxiety, and aggression has been demonstrated longitudinally, indicating that each may influence the course

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of the others and that family and contextual factors can moderate these relationships (Zhang et al., 2023). Anxiety may contribute to aggression when ambiguous interpersonal events are interpreted as threatening or intentionally harmful, particularly when emotion-regulation capacities are limited (Wehde, 2020). Aggression may also emerge when emotional distress cannot be adequately symbolized, expressed, or regulated and is instead discharged behaviorally. Research on aggression has shown that it is influenced by family processes, deficits in social competence, and difficulties in adaptive interpersonal functioning (Shayegh et al., 2021). Moreover, aggressive behavior itself can sometimes emerge or intensify as an unintended behavioral response to aversive contingencies or emotionally challenging interventions, underscoring the importance of understanding the functional and emotional context in which aggression occurs (Slocum et al., 2023). These findings suggest that aggression among women with depression and social anxiety should be understood not merely as an externalized behavior but as a possible manifestation of deeper emotional and regulatory difficulties.

Emotion regulation appears to be a particularly important mechanism linking depressive symptoms, anxiety, rumination, and aggression. Emotion-regulation difficulties can increase vulnerability to prolonged negative affect, impulsive behavior, maladaptive coping, and dysfunctional interpersonal responses. Research has demonstrated that emotion-regulation problems mediate relationships between psychological stressors and outcomes such as depression and aggression, indicating that ineffective regulation may constitute a common pathway connecting internalizing and externalizing symptoms (Mellat et al., 2022). Emotional suppression is also relevant because repeated inhibition of painful affect may intensify psychological distress and contribute to self-destructive cognition and behavior (Heshmati et al., 2023). Such patterns may be rooted in earlier experiences; childhood trauma has been associated with adult depressive and anxiety disorders through interacting psychological and biological mechanisms, including negative self-schemas, altered stress reactivity, interpersonal insecurity, and maladaptive emotion regulation (Kuzminskaite et al., 2021). From this perspective, treatment may need to address both present-focused regulatory deficits and the emotional meanings, defenses, and relational patterns underlying them. This is particularly relevant for patients whose rumination functions as a cognitive strategy for avoiding direct emotional experience or whose aggression reflects difficulty tolerating, identifying, and expressing affective states.

Dialectical behavior therapy is one prominent treatment approach designed to address emotional and behavioral dysregulation. Originally developed for individuals with severe and chronic emotion-regulation difficulties, DBT integrates behavioral principles, acceptance strategies, mindfulness, dialectical thinking, and skills training. Its major components include mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness, with the general aim of helping individuals recognize emotional experiences, tolerate distress without maladaptive action, regulate intense affect, and respond more effectively within relationships (Linehan, 2020). Because these mechanisms cut across diagnostic categories, DBT has increasingly been considered within transdiagnostic intervention frameworks for emotional disorders, including depression and anxiety (Liu et al., 2024). The emphasis on balancing acceptance and change is particularly relevant for individuals who alternate between emotional avoidance and dysregulated behavioral responses. Through mindfulness, individuals learn to observe thoughts and emotions without automatically reacting to them; through distress tolerance, they develop alternatives to impulsive or avoidant coping; through emotion-regulation training, they identify and modify emotional vulnerability; and through interpersonal-effectiveness skills, they learn more adaptive methods of expressing needs and resolving conflict.

Empirical evidence supports the usefulness of DBT for a range of emotional and behavioral outcomes. DBT skills training has been shown to reduce symptoms of anxiety and depression, suggesting that its regulatory and mindfulness components can improve internalizing symptoms even outside its original clinical indications (Barani & Fooladchang, 2022). DBT has also demonstrated reductions in depressive symptoms among adolescents in acute psychiatric settings (Saito et al., 2020), while research among adolescent girls with suicidal tendencies has reported beneficial effects on depressive symptoms and self-harming behaviors (Mahmoudi & Amini, 2025). In relation to aggression specifically, DBT has been associated with reductions in aggression, anxiety, and attentional difficulties among girls with obsessive-compulsive symptoms (Amighi et al., 2025). It has also been shown to improve emotion regulation and reduce aggression among female adolescents presenting with depressive symptoms (Cherati et al., 2023). Comparative research among delinquent adolescents has further suggested that DBT may reduce aggression and self-

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harming behavior and improve emotional self-regulation, although its effects may vary in comparison with other interventions (Damavandian et al., 2021). Collectively, these findings suggest that DBT offers an empirically grounded framework for targeting emotional instability and maladaptive behavioral reactions, but they also indicate that its effectiveness may differ depending on the clinical population and the specific outcome under consideration.

Despite the strengths of skills-based approaches, some patients may require therapies that focus more directly on unresolved emotional conflicts, unconscious defensive processes, and the meanings underlying recurrent symptoms. Psychodynamic therapies conceptualize symptoms not only as isolated behavioral or cognitive problems but also as expressions of internal conflict, defensive organization, attachment-related patterns, and difficulties in experiencing and integrating affect. Within intensive short-term dynamic approaches, therapeutic work often focuses on helping individuals recognize avoided feelings, identify anxiety that arises in response to emotional activation, clarify defensive responses, and gradually increase the capacity to experience and express underlying emotions. Research into mechanisms of change in intensive short-term dynamic psychotherapy has emphasized the therapeutic importance of emotional experiencing, defense restructuring, and increased access to previously avoided affect (Hoviatdoost, 2022). Dynamic psychotherapy has also demonstrated efficacy in treatment-resistant depression, with improvements maintained during extended follow-up, suggesting that interventions targeting underlying emotional and interpersonal mechanisms may generate durable benefits (Town et al., 2020). In social anxiety disorder, intensive short-term dynamic psychotherapy has likewise been examined experimentally, and evidence suggests that specific therapeutic processes such as therapeutic challenge and confrontation can contribute to meaningful clinical change (Rahmani et al., 2020).

Emotion-focused therapy shares with psychodynamic approaches an emphasis on emotional experience but places particular importance on accessing, differentiating, transforming, and integrating maladaptive emotional states. Within this framework, emotions are not simply symptoms to be suppressed; they are adaptive information-processing systems that can become problematic when they remain unprocessed, are chronically avoided, or are organized around maladaptive emotional schemas. Contemporary emotion-focused approaches to social anxiety emphasize transforming shame, fear, self-criticism, and vulnerability by creating corrective emotional experiences and increasing adaptive emotional processing (Shahar, 2020). Emotion-oriented interventions have also demonstrated beneficial effects on psychological characteristics associated with interpersonal and relational distress, suggesting that direct engagement with affective experience can facilitate broader changes in self-perception and attachment-related functioning (Ghaffari et al., 2022). From an integrative perspective, combining psychodynamic and emotion-focused principles may therefore offer a coherent method for working with patients whose difficulties involve both maladaptive emotion regulation and deeper defensive avoidance of affect. Techniques such as clarification, confrontation, role-playing, empty-chair work, identification of anxiety, and exploration of defenses can help patients move from repetitive intellectualization or rumination toward direct emotional awareness and processing.

Such an integrative approach may be particularly relevant to aggression. Psychodynamic theory has long regarded aggression as a complex phenomenon that may reflect defensive responses, unresolved conflict, shame, fear, humiliation, attachment injury, and disowned emotional states. Contemporary psychodynamic work emphasizes the need for therapists to recognize aggression both as an interpersonal behavior and as meaningful affective communication within the therapeutic relationship (Shapiro, 2024). When anger and aggression are treated only as behaviors to be inhibited, the emotional conditions generating them may remain unchanged; by contrast, exploring the underlying feelings and defensive sequences may allow patients to understand how aggression develops and to replace it with more integrated forms of emotional expression. The relevance of this perspective is strengthened by evidence that social anxiety can coexist with anger, hostile cognition, and aggression, particularly when individuals repeatedly ruminate about interpersonal threat or perceived rejection (Farajinia et al., 2020). In addition, interventions that increase coping capacity and interpersonal competence can reduce social anxiety, indicating that changes in emotion management and social functioning may interact with symptom reduction (Rigi Koteh et al., 2020).

The potential value of psychodynamic emotion-focused treatment is also supported by broader evidence regarding emotional avoidance and treatment resistance. Individuals with depression and anxiety may develop habitual patterns of suppressing, avoiding, or overcontrolling affect, which can paradoxically sustain symptoms. Childhood adversity and accumulated relational experiences may further shape

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defensive patterns and influence how individuals interpret current interpersonal situations (Kuzminskaite et al., 2021). When painful emotions cannot be consciously processed, patients may engage in repetitive thinking, withdrawal, self-criticism, somatic tension, or aggressive behavior as substitute forms of regulation. Accordingly, a therapeutic model that helps individuals identify feelings, distinguish emotions from anxiety, recognize habitual defenses, and tolerate previously avoided affect may theoretically exert simultaneous effects on both rumination and aggression. This may be especially useful in comorbid depression and social anxiety, where cognitive repetition, interpersonal avoidance, shame, and emotional inhibition frequently coexist. Dynamic treatment research has shown that work focused on emotional conflict can be effective in both depression and social anxiety (Rahmani et al., 2020; Town et al., 2020), while emotion-focused developments specifically targeting social anxiety highlight the importance of transforming maladaptive emotional schemas rather than relying exclusively on behavioral exposure or cognitive restructuring (Shahar, 2020).

At the same time, DBT and psychodynamic emotion-focused therapy represent meaningfully different therapeutic pathways. DBT is primarily organized around the acquisition and repeated practice of explicit skills intended to improve present-focused coping, whereas psychodynamic emotion-focused therapy emphasizes the experiential processing of underlying affect, anxiety, defenses, and recurring relational patterns. DBT may therefore be particularly effective when difficulties are maintained by limited coping repertoires, impulsivity, or deficient emotion-regulation skills, whereas a psychodynamic emotion-focused intervention may offer additional benefits when symptoms arise from recurrent emotional conflicts or defensive avoidance. The available literature indicates that DBT can improve depression, anxiety, aggression, self-harm, and emotion regulation across several populations (Amighi et al., 2025; Barani & Fooladchang, 2022; Cherati et al., 2023; Damavandian et al., 2021; Saito et al., 2020), but direct comparisons with interventions emphasizing deeper emotional processing remain limited, particularly among adult women experiencing comorbid depression and social anxiety. Moreover, evidence suggesting transdiagnostic applications of DBT remains under active development (Liu et al., 2024), making comparative studies useful for identifying which intervention may be more suitable for specific outcomes such as rumination versus aggression.

Another important issue is that comorbidity requires intervention strategies capable of addressing shared mechanisms without overlooking symptom-specific processes. Population-level evidence demonstrates that mood, anxiety, and comorbid disorders possess both shared and distinct risk factors (Hassan & Feng, 2026), and clinical research indicates that the coexistence of social anxiety and depression complicates therapeutic planning (Koyuncu et al., 2019). Rumination may function as a shared cognitive mechanism, whereas aggression may be more strongly related to dysregulated affect, interpersonal threat perception, or defensive responding. These differences raise the possibility that two treatments may produce similar changes in rumination while differing in their effects on aggression. Research on emotion regulation, depressive symptoms, and aggression supports the importance of examining these outcomes simultaneously rather than assuming that improvements in one automatically produce equivalent improvements in the other (Mellat et al., 2022). Similarly, findings concerning emotional suppression and self-destructive processes suggest that improving overt behavioral control without changing underlying emotional avoidance may leave important vulnerability mechanisms intact (Heshmati et al., 2023). Comparative intervention research can therefore clarify whether a skills-based approach and a depth-oriented emotional approach generate distinct patterns of change.

Taken together, the existing literature supports both DBT and emotionally focused psychodynamic interventions, yet important gaps remain regarding their comparative effectiveness in women with comorbid depression and social anxiety. Existing studies have examined DBT in relation to depressive symptoms, anxiety, aggression, self-harm, and emotional dysregulation in different populations (Amighi et al., 2025; Cherati et al., 2023; Mahmoudi & Amini, 2025), while psychodynamic and emotion-focused approaches have shown promise for treatment-resistant depression, social anxiety, emotional conflict, and relational difficulties (Ghaffari et al., 2022; Rahmani et al., 2020; Town et al., 2020). However, limited evidence directly compares these therapeutic models in a comorbid adult female population while simultaneously examining rumination and aggression and assessing whether therapeutic effects persist over follow-up. Addressing this gap may provide clinically useful information concerning treatment selection, particularly because women presenting with the same diagnostic combination may differ in whether repetitive negative

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thinking or aggressive emotional expression constitutes the more prominent difficulty.

Therefore, the present study aimed to compare the effectiveness of a psychodynamic emotion-focused therapy package and dialectical behavior therapy in reducing rumination and aggression among women with comorbid depression and social anxiety.

2. Methods and Materials

2.1. Study design and Participant

This study was conducted with the aim of developing a psychodynamic emotion-focused therapy package and comparing its effectiveness with dialectical behavior therapy in reducing rumination and aggression among women with comorbid depression and social anxiety. Methodologically, the study employed a sequential exploratory mixed-methods design consisting of a qualitative phase followed by a quantitative phase. In the qualitative phase, relevant scientific and clinical sources related to psychodynamic psychotherapy and emotion-focused approaches were systematically reviewed to identify therapeutic concepts, mechanisms, and techniques appropriate for the target population. The extracted material was analyzed using deductive thematic analysis, through which related concepts were organized into a thematic network. Based on the resulting themes, a preliminary list of therapeutic components and techniques was developed, including emotion identification, exploration of underlying affective experiences, empty-chair work, role-playing, identification of anxiety associated with emotional activation, clarification of defensive responses, and enhancement of the capacity to tolerate and process difficult emotions. The initial psychodynamic emotion-focused therapy package was subsequently reviewed by experts with relevant clinical and academic expertise, and revisions were made on the basis of their feedback before the final protocol was prepared for implementation. The quantitative phase was conducted using a quasi-experimental pretest-posttest design with a control group and a two-month follow-up. The statistical population consisted of single women aged 20 to 40 years who referred to counseling centers in Isfahan, Iran, and met the diagnostic criteria for concurrent depressive symptoms and social anxiety. From among eligible individuals, 45 participants were selected through purposive sampling and randomly allocated to three groups of 15 participants: psychodynamic emotion-focused therapy, dialectical behavior therapy, and control. All participants completed the study measures at pretest, immediately after the intervention period, and at the two-month follow-up. The two experimental groups received their respective therapeutic interventions, whereas the control group received no psychological intervention during the study period. Inclusion criteria were willingness to participate and provision of written informed consent, acceptance of the rules and requirements of group therapy, absence of concurrent psychiatric or psychological treatment during the study period, and confirmation of comorbid depression and social anxiety based on cutoff scores on the Beck Depression Inventory and Connor Social Anxiety Questionnaire together with clinical confirmation by a qualified mental health professional. Exclusion criteria included voluntary withdrawal from the study, failure to continue participation, or absence from more than two therapeutic sessions.

2.2. Measures

The Beck Depression Inventory was used to assess the severity of depressive symptoms and to assist in identifying eligible participants with clinically significant depression. This widely used self-report instrument consists of 21 items designed for adolescents and adults and evaluates cognitive, affective, motivational, and somatic manifestations of depression. Each item is scored according to increasing levels of symptom severity, with higher total scores indicating greater depressive symptomatology. The inventory has been extensively used in clinical and research settings because of its sensitivity to variations in depression severity and its usefulness in both screening and outcome assessment. Evidence regarding the Persian version has demonstrated satisfactory psychometric properties, with a reported Cronbach's alpha coefficient of 0.87 and a test-retest reliability coefficient of 0.73. Studies examining its criterion-related and concurrent validity have also indicated acceptable correspondence with other established measures and clinical evaluations of depressive symptoms. In the present study, scores on this inventory were used alongside clinical assessment to identify participants who met the study criteria for depression.

The Connor Social Anxiety Questionnaire was used to assess the severity of social anxiety symptoms and to support the identification of participants with comorbid social anxiety. The questionnaire consists of 17 items and evaluates three principal dimensions of social anxiety, including fear in social situations, avoidance of anxiety-provoking social contexts, and physiological discomfort associated with

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social interaction and performance situations. Responses are recorded on a five-point Likert scale ranging from 1, representing minimal or absent symptoms, to 5, representing a high level of symptom severity. Higher total scores indicate greater levels of social anxiety. The instrument has demonstrated strong internal consistency, with a reported Cronbach's alpha coefficient of 0.94, and test-retest reliability coefficients ranging from 0.78 to 0.89. Evidence of convergent validity has also been reported through significant correlations with other validated measures of anxiety and related constructs. In the present study, the questionnaire was used in conjunction with clinical evaluation to verify the presence of social anxiety among participants entering the intervention phase.

The Eysenck and Glenn Wilson Aggression Questionnaire was used to measure aggression as one of the principal outcome variables of the study. The questionnaire consists of 30 items designed to assess individual differences in aggressive tendencies and behavioral dispositions associated with hostility and aggression. Of the total items, 20 are phrased in a positive direction and 10 are phrased in a negative direction, requiring appropriate reverse scoring where applicable before calculating the total score. Higher scores represent greater levels of aggressive tendencies. The questionnaire has been used in psychological research to assess relatively stable aggressive characteristics as well as changes in aggression following psychological interventions. Previous psychometric evaluations have reported Cronbach's alpha coefficients ranging from 0.69 to 0.74, indicating acceptable internal consistency for research purposes, while evidence from the original validation studies supported the construct validity of the instrument. In the present study, aggression scores obtained at pretest, posttest, and follow-up were used to determine the extent to which the two therapeutic approaches differed in their capacity to reduce aggressive tendencies over time.

The Nolen-Hoeksema and Morrow Rumination Response Scale was employed to assess rumination as the second principal outcome variable. The scale contains 22 items designed to evaluate repetitive and passive patterns of thinking that occur in response to negative mood states and distressing experiences. The instrument assesses the tendency to focus repeatedly on negative emotions, their possible causes, and their perceived consequences rather than engaging in active problem solving or adaptive coping. The scale includes dimensions reflecting ruminative responses and distractive responses, and items are rated using a Likert-type response format, with higher scores indicating a greater tendency toward maladaptive rumination. Previous psychometric investigations have demonstrated strong internal consistency, with a Cronbach's alpha coefficient of approximately 0.90 for the total scale and coefficients of 0.92 and 0.89 for its respective subscales. Evidence of convergent validity has also been reported, including a correlation coefficient of 0.65 with measures of dysfunctional cognitive beliefs. In the present study, the scale was administered at all three measurement points to evaluate immediate and sustained changes in rumination following the interventions.

2.3. Interventions

The dialectical behavior therapy intervention was delivered in 10 structured sessions based on the major skills domains of mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. The first session introduced participants to the treatment framework, the concept of dialectics, and basic mindfulness strategies, including observing, describing, and participating in present-moment experience. The second session expanded mindfulness training through exercises aimed at strengthening wise-mind functioning, practicing radical acceptance, increasing effective awareness, and identifying barriers to mindful engagement. The third session focused on acceptance-based distress tolerance strategies, including radical acceptance, observing the breath, and the use of a gentle smile as a means of reducing physiological and emotional tension. The fourth session introduced change-oriented distress tolerance strategies such as distraction, self-soothing, and positive imagery, while the fifth session emphasized relaxation, remaining present in the moment, and the development of adaptive coping responses. The sixth session addressed emotion regulation through psychoeducation regarding the dimensions, categories, functions, and analysis of emotions. The seventh session focused on identifying emotions as they occur, reducing emotional vulnerability, and increasing positive emotional experiences. The eighth session taught more advanced emotion-regulation strategies, including nonjudgmental awareness of emotional states, direct confrontation with difficult emotions, and systematic problem-solving skills. The ninth session introduced interpersonal effectiveness by examining behavioral interaction styles, difficulties in identifying and expressing needs, dysfunctional relationships, and maladaptive interpersonal beliefs. The tenth session consolidated interpersonal effectiveness skills

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through training in awareness of interpersonal situations, assertive requests, active listening, negotiation, and conflict-resolution strategies. Across sessions, participants were encouraged to practice the learned skills between meetings and to apply them to emotionally distressing and interpersonal situations associated with depression, social anxiety, rumination, and aggression.

The psychodynamic emotion-focused therapy package was implemented in eight structured sessions and was developed specifically through integration of psychodynamic principles with emotion-focused therapeutic techniques. The first session concentrated on precise identification and formulation of the participant's primary problem through targeted therapeutic questioning, with particular attention to recurrent interpersonal and emotional difficulties. The second session focused on exploration and identification of emotions and affective experiences associated with the identified problem, enabling participants to recognize emotions that had previously been avoided, minimized, or insufficiently differentiated. The third session addressed anxiety and tension activated by these emotional experiences, with attention to both psychological manifestations and physiological responses. During the fourth session, participants were helped to identify unconscious or habitual defensive strategies used to avoid, suppress, or manage painful feelings and emotions. The fifth session involved clarification of these defensive patterns and therapeutic confrontation with maladaptive ways of managing affect, while maintaining sufficient emotional safety for deeper exploration. The sixth session examined the participant's broader emotional process as an integrated cycle, including emotional activation, anxiety, defensive responses, avoidance patterns, and behavioral consequences. The seventh session explored alternative and more adaptive methods of responding to difficult emotions and examined additional emotional or interpersonal problems that could be addressed using the same therapeutic framework. The final session was devoted to consolidating awareness, emotional insight, and the participant's capacity to recognize, tolerate, process, and express feelings in more adaptive ways. Techniques such as emotion identification, experiential exploration, empty-chair work, role-playing, clarification, and confrontation were incorporated when clinically appropriate, with the overall aim of modifying deeper emotional processes and defensive patterns associated with rumination and aggression.

2.4. Data Analysis

Data from the quantitative phase were analyzed using descriptive and inferential statistical procedures. Before conducting the main analyses, the data were screened for accuracy, missing values, and potential violations of the assumptions required for repeated-measures analysis. The distribution of the dependent variables was examined for normality, and relevant assumptions concerning homogeneity of variances, covariance structure, and sphericity were evaluated prior to interpreting the inferential results. Repeated-measures analysis of variance was then used to examine changes in rumination and aggression across the three assessment points of pretest, posttest, and two-month follow-up and to determine whether the pattern of change differed significantly among the psychodynamic emotion-focused therapy, dialectical behavior therapy, and control groups. Where statistically significant overall or interaction effects were observed, Bonferroni-adjusted post-hoc comparisons were performed to identify specific between-group and within-group differences while controlling for inflation of Type I error due to multiple comparisons. Statistical significance was evaluated at the conventional alpha level of .05, with more stringent probability values reported where applicable.

3. Findings and Results

The participants in the three study groups were comparable with respect to age. The mean age of participants in the psychodynamic emotion-focused therapy group was 29.86 years (SD = 4.96), compared with 29.13 years (SD = 6.51) in the dialectical behavior therapy group and 30.40 years (SD = 4.93) in the control group. Across the entire sample, the mean age was 29.80 years (SD = 5.42). The results of one-way analysis of variance indicated that there was no statistically significant difference in mean age among the psychodynamic emotion-focused therapy, dialectical behavior therapy, and control groups ($p = .820$), indicating that the three groups were homogeneous in terms of age at baseline.

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Table 1

Mean and Standard Deviation of Rumination and Aggression by Group and Measurement Time

Measurement Time	Variable	Psychodynamic Therapy, Mean	Emotion-Focused	SD	Dialectical Behavior Therapy, Mean	SD	Control, Mean	SD
Pretest	Rumination	65.00		9.58	62.33	8.81	62.66	8.08
	Aggression	46.46		7.70	46.86	6.37	44.06	5.70
Posttest	Rumination	49.86		8.64	50.20	9.71	62.86	7.83
	Aggression	30.40		6.24	37.86	4.61	44.00	5.61
Follow-up	Rumination	48.66		8.82	49.26	8.87	63.46	8.45
	Aggression	29.01		5.85	37.26	4.75	44.93	4.90

As shown in Table 1, the mean rumination scores in both intervention groups decreased substantially from pretest to posttest and remained at approximately the same reduced level at the two-month follow-up. In the psychodynamic emotion-focused therapy group, mean rumination decreased from 65.00 (SD = 9.58) at pretest to 49.86 (SD = 8.64) at posttest and 48.66 (SD = 8.82) at follow-up. Similarly, in the dialectical behavior therapy group, the mean decreased from 62.33 (SD = 8.81) to 50.20 (SD = 9.71) and subsequently to 49.26 (SD = 8.87). In contrast, rumination scores in the control group remained relatively stable across pretest, posttest, and follow-up. A different pattern was apparent for aggression. The psychodynamic emotion-focused therapy group demonstrated a pronounced decrease from 46.46 (SD = 7.70) at pretest to 30.40 (SD = 6.24) at posttest and 29.01 (SD = 5.85) at follow-up. Aggression also decreased in the dialectical behavior therapy group from 46.86 (SD = 6.37) at pretest to 37.86 (SD = 4.61) at posttest and 37.26 (SD = 4.75) at follow-up, whereas the control group showed little change across the three measurement occasions.

Before conducting repeated-measures analysis of variance, the relevant statistical assumptions were examined. The Shapiro-Wilk test indicated that the distributions of rumination and aggression scores at pretest, posttest, and follow-up did not significantly deviate from normality, with all significance values exceeding .05. Levene's test was also nonsignificant at all three measurement occasions for both dependent variables, supporting the assumption of homogeneity of error variances. Box's M test yielded M = 34.798, p = .002 for rumination and M = 26.981, p = .019 for aggression. Given the conservative significance criterion of .001 commonly adopted because of the sensitivity of Box's M test, these findings did not indicate a substantial violation of homogeneity of covariance matrices under the specified criterion. In contrast, Mauchly's test of sphericity was significant for both rumination (W = .456, p = .001) and aggression (W = .393, p = .001), indicating violation of the sphericity assumption. Accordingly, Greenhouse-Geisser corrections were applied to the within-subject effects. The corrected repeated-measures analysis demonstrated a significant effect of time on rumination, F = 288.731, p = .001, as well as a significant time × group interaction, F = 83.518, p = .001. The between-group effect was also significant, F = 5.217, p = .009. For aggression, the effect of time was significant, F = 198.275, p = .001, as was the time × group interaction, F = 66.877, p = .001, while the overall between-group effect was likewise significant, F = 10.372, p = .001. These findings indicated that changes in both outcome variables over time differed significantly according to treatment condition and justified subsequent pairwise comparisons using the Bonferroni procedure.

Table 2

Bonferroni Post-Hoc Pairwise Comparisons of Rumination and Aggression by Time and Group

Comparison Dimension	Variable	Base Category	Comparison Category	Mean Difference	Standard Error	p
Time	Rumination	Pretest	Posttest	9.022	0.523	.001
		Pretest	Follow-up	9.533	0.521	.001
		Posttest	Follow-up	0.511	0.229	.093
Time	Aggression	Pretest	Posttest	8.400	0.557	.001
		Pretest	Follow-up	8.756	0.612	.001
		Posttest	Follow-up	0.356	0.241	.445
Group	Rumination	Psychodynamic Therapy Emotion-Focused	Dialectical Behavior Therapy	0.578	3.143	1.000

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		Psychodynamic Therapy	Emotion-Focused	Control		-8.489	3.143	.030
		Dialectical Behavior Therapy		Control		-9.067	3.143	.018
Group	Aggression	Psychodynamic Therapy	Emotion-Focused	Dialectical Therapy	Behavior	-5.3778	2.00217	.031
		Psychodynamic Therapy	Emotion-Focused	Control		-9.0667	2.00217	.001
		Dialectical Behavior Therapy		Control		-3.6889	2.00217	.217

As presented in Table 2, Bonferroni-adjusted pairwise comparisons showed that rumination decreased significantly from pretest to posttest (MD = 9.022, SE = 0.523, p = .001) and from pretest to the two-month follow-up (MD = 9.533, SE = 0.521, p = .001), whereas the difference between posttest and follow-up was not statistically significant (MD = 0.511, SE = 0.229, p = .093). This pattern indicates that the reduction achieved after treatment was maintained during the follow-up period. For aggression, significant reductions were similarly observed from pretest to posttest (MD = 8.400, SE = 0.557, p = .001) and from pretest to follow-up (MD = 8.756, SE = 0.612, p = .001), while the posttest-to-follow-up difference was nonsignificant (MD = 0.356, SE = 0.241, p = .445), demonstrating maintenance of treatment-related changes. Regarding between-group comparisons for rumination, there was no significant difference between psychodynamic emotion-focused therapy and dialectical behavior therapy (MD = 0.578, SE = 3.143, p = 1.000), indicating comparable effectiveness of the two interventions. However, psychodynamic emotion-focused therapy produced significantly lower rumination scores than the control condition (MD = -8.489, SE = 3.143, p = .030), and dialectical behavior therapy also differed significantly from the control group (MD = -9.067, SE = 3.143, p = .018). For aggression, psychodynamic emotion-focused therapy resulted in significantly lower scores than both dialectical behavior therapy (MD = -5.3778, SE = 2.00217, p = .031) and the control group (MD = -9.0667, SE = 2.00217, p = .001). In contrast, the difference between dialectical behavior therapy and the control condition was not statistically significant (MD = -3.6889, SE = 2.00217, p = .217). Collectively, these results indicate that both interventions were effective in reducing rumination, whereas psychodynamic emotion-focused therapy demonstrated a comparatively stronger and statistically significant effect on aggression.

4. Discussion

The present study compared the effectiveness of a psychodynamic emotion-focused therapy package and dialectical behavior therapy in reducing rumination and aggression among women with comorbid depression and social anxiety. The findings showed that both interventions significantly reduced rumination compared with the control group, and the reductions remained stable at the two-month follow-up. No significant difference was found between the psychodynamic emotion-focused therapy and dialectical behavior therapy groups with respect to rumination, suggesting that both approaches were comparably effective in modifying repetitive negative thinking. In contrast, a different pattern emerged for aggression. Psychodynamic emotion-focused therapy produced a significantly greater reduction in aggression than both dialectical behavior therapy and the control condition, whereas the difference between dialectical behavior therapy and the control group was not statistically significant. The maintenance of treatment gains from posttest to follow-up for both outcomes also indicates that the observed changes were not merely immediate reactions to participation in the interventions but showed short-term stability after treatment completion.

The significant reduction in rumination observed in both intervention groups is consistent with the broader literature identifying repetitive negative thinking as a modifiable transdiagnostic process. Rumination is recognized as a central mechanism involved in the onset, maintenance, and recurrence of emotional disorders because it intensifies negative affect, prolongs cognitive engagement with distressing material, and limits effective problem solving (Watkins & Roberts, 2020). Individuals with depression and social anxiety may become caught in persistent cycles of self-focused attention, anticipation of negative evaluation, post-event review, and repetitive analysis of perceived failures. These processes are especially relevant in comorbid presentations because social anxiety can amplify self-monitoring and avoidance, while depression can reinforce hopelessness and negative self-evaluation. The finding that both treatments reduced rumination therefore supports the assumption that interventions capable of modifying emotional regulation and internal processing can interrupt repetitive cognitive cycles even when they originate from different theoretical traditions.

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The effectiveness of dialectical behavior therapy in reducing rumination can be explained by its emphasis on mindfulness, emotion regulation, and distress tolerance. Mindfulness skills encourage individuals to observe thoughts and emotions as temporary internal events rather than unquestioned facts that require prolonged analysis. This shift from cognitive fusion toward nonjudgmental observation may weaken the repetitive elaboration characteristic of rumination. Distress tolerance skills may similarly reduce the need to mentally revisit distressing experiences as a maladaptive attempt to gain certainty or emotional control. Emotion-regulation skills further support identification, labeling, and modulation of affective states before they escalate into prolonged negative thinking. These mechanisms are consistent with the theoretical framework of DBT, which emphasizes balancing acceptance and change and developing concrete skills for managing emotionally intense experiences (Linehan, 2020). The present findings are also aligned with evidence that DBT skills training reduces anxiety and depressive symptoms (Barani & Fooladchang, 2022), that DBT-informed interventions have potential as transdiagnostic treatments for emotional disorders (Liu et al., 2024), and that DBT can reduce depressive symptoms in clinically distressed populations (Mahmoudi & Amini, 2025; Saito et al., 2020). Although these studies did not always assess rumination directly, the reduction of depressive and anxiety symptoms through improved emotional regulation provides a plausible empirical foundation for the present result.

The reduction in rumination following psychodynamic emotion-focused therapy may involve somewhat different mechanisms. Rather than primarily teaching skills for managing thoughts and emotions, this approach seeks to identify the underlying emotional conflicts, anxiety, and defensive responses that organize repetitive cognitive patterns. Rumination can function as a defensive process through which an individual remains cognitively preoccupied while avoiding direct contact with painful affective experiences. From this perspective, repetitive thinking may substitute for experiencing grief, anger, fear, shame, guilt, or unmet attachment needs. By helping participants identify emotions, distinguish emotional experience from anxiety, recognize defenses, and remain in contact with previously avoided affect, psychodynamic emotion-focused therapy may reduce the psychological need for repetitive cognitive processing. This explanation is consistent with mechanisms described in intensive short-term dynamic psychotherapy, where change is associated with increased emotional experiencing, reduced reliance on defenses, and improved access to avoided affect (Hoviatdoost, 2022). It is also in line with findings supporting the efficacy of intensive short-term dynamic psychotherapy in treatment-resistant depression (Town et al., 2020) and social anxiety disorder (Rahmani et al., 2020), as well as developments in emotion-focused therapy emphasizing the transformation of maladaptive emotional experiences in social anxiety (Shahar, 2020).

The absence of a significant difference between the two active treatments for rumination is theoretically meaningful. Although DBT and psychodynamic emotion-focused therapy differ substantially in their assumptions and techniques, both may influence the same maintaining process from different directions. DBT may reduce rumination through attentional control, present-moment awareness, distress tolerance, and emotion-regulation skills, whereas psychodynamic emotion-focused therapy may reduce it through emotional clarification, defense restructuring, and deeper processing of unresolved affect. In both cases, the individual becomes less likely to remain trapped in repetitive, abstract, self-focused thought. This interpretation is supported by research showing that emotional processing is an important therapeutic target across different psychological interventions. Acceptance and commitment therapy, for example, has been found to improve emotional processing and reduce rumination in anxiety-related conditions (Sharif Ara et al., 2023). Moreover, emotion-oriented interventions have shown beneficial effects on emotional and relational functioning among distressed women (Ghaffari et al., 2022). The present findings therefore suggest that rumination may be sufficiently transdiagnostic that distinct interventions can achieve similar outcomes when they successfully alter emotional avoidance and maladaptive regulation.

The findings concerning aggression were more differentiated and showed a clear advantage for psychodynamic emotion-focused therapy. Participants receiving this intervention demonstrated significantly greater reductions in aggression than those receiving dialectical behavior therapy and those in the control condition. This result is notable because aggression is often conceptualized as a behavioral manifestation of dysregulated affect, but it may also reflect deeper conflicts involving shame, rejection, humiliation, fear, resentment, and defensive hostility. Psychodynamic conceptualizations emphasize that aggressive behavior can represent an attempt to manage or discharge painful affect that cannot be

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consciously tolerated or symbolically processed. Contemporary psychodynamic work has highlighted the importance of understanding aggression not merely as problematic behavior but as psychologically meaningful material that may emerge in relation to interpersonal conflict, defenses, and unmet emotional needs (Shapiro, 2024). In the present intervention, the systematic identification of feelings, anxiety, defensive responses, and maladaptive coping patterns may have helped participants understand the emotional sequence preceding aggressive reactions and replace automatic defensive responding with greater emotional awareness and regulation.

The superiority of psychodynamic emotion-focused therapy for aggression may also be explained by its direct attention to underlying affective conflicts rather than primarily to behavioral control. Women with comorbid depression and social anxiety may suppress anger because of fears of rejection, disapproval, or loss of relationships. Over time, suppressed anger can coexist with internalized distress, self-criticism, rumination, and sudden aggressive expression. Emotional suppression has been associated with severe forms of psychological distress and self-destructive processes, indicating that avoidance of affect may intensify rather than resolve emotional problems (Heshmati et al., 2023). In addition, childhood trauma and adverse relational experiences can shape enduring patterns of emotional dysregulation, avoidance, interpersonal threat sensitivity, and maladaptive defensive responses (Kuzminskaite et al., 2021). Psychodynamic emotion-focused therapy may be particularly suited to such patterns because it seeks to uncover the affective meaning of aggression and help individuals experience and integrate the emotions that aggressive behavior previously defended against.

The present finding also aligns with evidence that depression, social anxiety, and aggression are reciprocally related rather than independent phenomena. Longitudinal research has demonstrated bidirectional relationships among these variables, with family functioning influencing the strength of these associations (Zhang et al., 2023). Other studies have shown that anger rumination and aggression are significant predictors of social anxiety (Farajinia et al., 2020), suggesting that hostility and repetitive negative cognition may interact within the same emotional system. Furthermore, difficulties in emotion regulation have been shown to mediate relationships involving stress, depression, and aggression (Mellat et al., 2022). These findings support the idea that successful treatment of aggression in individuals with depression and social anxiety may require more than suppressing aggressive responses; it may require modification of the emotional processes that generate and maintain them.

At first glance, the nonsignificant difference between dialectical behavior therapy and the control group for aggression may appear inconsistent with previous studies showing that DBT can reduce aggression. For example, DBT has been reported to reduce aggression among girls with obsessive-compulsive disorder (Amighi et al., 2025), improve aggression and emotion-regulation difficulties in female adolescents with depressive symptoms (Cherati et al., 2023), and reduce aggression in delinquent adolescents (Damavandian et al., 2021). However, differences in sample characteristics, developmental stage, baseline severity, treatment setting, treatment dosage, and the mechanisms underlying aggression may account for the discrepancy. Participants in the present study were adult women with comorbid depression and social anxiety rather than adolescents with behavioral dysregulation or forensic involvement. Their aggression may therefore have been more closely connected to internalized emotional conflict, suppression, shame, or interpersonal threat sensitivity than to overt impulsivity. Under such conditions, a treatment focused on deeper emotional processing may produce stronger effects than a skills-based approach.

It is also possible that the duration and emphasis of the DBT intervention influenced the aggression results. Standard DBT is a comprehensive treatment model that may include individual therapy, skills training, between-session coaching, and therapist consultation, whereas the present study employed a structured skills-oriented protocol emphasizing mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Although these components are clinically important, their effects on aggression may require more intensive repetition, individualized behavioral chain analysis, or longer treatment exposure. DBT remains strongly supported as a treatment for emotional and behavioral dysregulation, and its theoretical framework specifically addresses impulsive and maladaptive behaviors (Linehan, 2020). Therefore, the present result should not be interpreted as evidence that DBT is generally ineffective for aggression; rather, it suggests that within this specific population and treatment format, psychodynamic emotion-focused therapy produced a stronger measurable effect.

The findings may also be interpreted in light of the relationship between anxiety and aggression. Research indicates that aggression can emerge in response to

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perceived social threat, hostile intent attribution, and impaired emotion regulation (Wehde, 2020). Individuals with social anxiety may be especially sensitive to rejection, criticism, embarrassment, and ambiguous interpersonal cues. Although their anxiety often produces avoidance, in some cases accumulated tension may also manifest as irritability, hostility, or defensive aggression. Social skills and adaptive coping can reduce social anxiety (Rigi Koteh et al., 2020), and family and interpersonal competence are also related to aggressive behavior (Shayegh et al., 2021). Psychodynamic emotion-focused therapy may reduce aggression by altering the subjective interpretation of emotionally charged social situations, increasing tolerance of vulnerable affect, and reducing defensive escalation. This could be especially important when aggression is secondary to shame or perceived interpersonal injury rather than primarily driven by impulsivity.

The maintenance of improvements from posttest to follow-up is another important finding. For both rumination and aggression, no significant deterioration occurred between the posttest and two-month follow-up assessments. This suggests that participants were able to retain at least some of the cognitive and emotional changes acquired during treatment. Stability after intervention is clinically important because short-term symptom improvement may have limited value if patients quickly return to previous patterns. Psychodynamic approaches may support maintenance through increased insight into recurring emotional cycles and defenses, while DBT may support maintenance through continued use of learned skills. Evidence that dynamic psychotherapy can produce durable effects beyond treatment termination has been reported in longer-term follow-up studies of depression (Town et al., 2020). Similarly, the structured skills taught in DBT are designed for continued use after treatment, potentially allowing participants to generalize emotion-regulation strategies to future stressors (Linehan, 2020). The sustained reductions observed in the present study therefore strengthen the clinical relevance of both interventions for rumination and of psychodynamic emotion-focused therapy for aggression.

5. Conclusion

Overall, the results suggest that the two interventions may be suitable for somewhat different therapeutic priorities. When repetitive negative thinking is the principal difficulty, either psychodynamic emotion-focused therapy or DBT may be appropriate because both approaches appear capable of reducing rumination. In contrast, when aggression is prominent, psychodynamic emotion-focused therapy may offer additional benefit by directly addressing the emotional conflicts, defenses, and inhibited affect underlying aggressive reactions. These findings are compatible with the broader view that comorbid mood and anxiety disorders involve both shared and distinct mechanisms (Hassan & Feng, 2026). Social anxiety comorbidity also complicates treatment because it increases symptom burden and may require interventions that address overlapping emotional and interpersonal processes (Koyuncu et al., 2019). Accordingly, treatment selection may benefit from moving beyond diagnosis alone and considering the dominant maintaining mechanisms and symptom patterns of each patient.

6. Limitations and Suggestions

The present study had several limitations that should be considered when interpreting the findings. The sample consisted exclusively of single women aged 20 to 40 years who were recruited from counseling centers in Isfahan, which limits the generalizability of the results to men, married women, other age groups, community samples, and individuals from different cultural or geographical contexts. The sample size was relatively modest, with 15 participants in each condition, which may have limited statistical power for detecting smaller between-group differences. In addition, the follow-up period was restricted to two months, and therefore the longer-term durability of the treatment effects remains uncertain. Outcomes were assessed primarily through self-report measures, which may be influenced by social desirability, response bias, or participants' awareness of treatment allocation. The control group received no active intervention, making it difficult to separate specific treatment effects from nonspecific factors such as therapist attention, group support, and expectancy. Finally, although participants were screened for comorbid depression and social anxiety, individual variation in symptom severity, personality characteristics, trauma history, and prior treatment experiences may have affected responsiveness to the interventions.

Future studies should replicate these findings using larger and more diverse samples and include participants of different genders, marital statuses, age groups, and cultural backgrounds. Longer follow-up periods, such as six months or one year, would provide stronger evidence regarding the maintenance of therapeutic gains and the possibility of

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delayed relapse. Future research should also use active comparison conditions and include clinician-rated or behavioral measures alongside self-report instruments to strengthen measurement validity. It would be useful to examine potential mediators of change, including emotional awareness, experiential avoidance, defensive functioning, emotion-regulation capacity, shame, anger suppression, and mindfulness, in order to clarify why the two interventions produce similar effects on rumination but different effects on aggression. Comparative dismantling studies could also identify which specific components of the psychodynamic emotion-focused package contribute most strongly to aggression reduction. In addition, future studies may examine whether baseline characteristics such as trauma history, aggression severity, social avoidance, or rumination style predict differential response to the two interventions.

From a practical perspective, clinicians working with women who present with concurrent depression and social anxiety may consider both psychodynamic emotion-focused therapy and DBT when rumination is a prominent treatment target. DBT may be especially useful when patients benefit from a structured, skills-based format emphasizing mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Psychodynamic emotion-focused therapy may be particularly useful when aggression, suppressed anger, recurrent interpersonal conflict, emotional avoidance, or poorly understood affective reactions are central clinical features. Assessment before treatment should therefore include not only diagnostic symptoms but also the dominant emotional and behavioral mechanisms maintaining distress. Treatment planning may be improved by matching the intervention to the patient's predominant difficulties, and integrative programs may also combine DBT skills with deeper emotion-focused and psychodynamic work when both immediate regulation and underlying emotional processing are needed.

Authors' Contributions

Authors equally contributed to this article.

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

Transparency Statement

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Declaration of Interest

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Ethical Considerations

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