IJBMC
International Journal of Body, Mind and Culture

Volume 13, Issue 9, Article e2026-1334
DOI: 10.61838/ijbmc.v13i9.1334

Article type:
Original Research

1 Department of Psychology, SR.C., Islamic Azad University, Tehran, Iran.
2 Assistant Professor, Department of Clinical and Health Psychology, Ka.c., Islamic Azad University, Karaj, Iran.
3 Department of Psychology, ShB.C., Islamic Azad University, Shahrbabak, Iran.

Comparison of the Effectiveness of Short-Term Psychodynamic Therapy and Schema Therapy on Childhood Trauma in Women with Emotional Divorce

Corresponding author email address:
ta.ranjbaripour@iau.ac.ir

Mehrzahra. Zabihifard[1], Tahereh. Ranjbaripour[2*], Marzieh. Gholami Touranposhti[3]

Article history:

Received 23 Mar 2026
Revised 18 May 2026
Accepted 20 May 2026
Published online 01 Aug 2026

How to cite this article:
Zabihifard, M., Ranjbaripour, T., & Gholami Touranposhti, M. (2026). Comparison of the Effectiveness of Short-Term Psychodynamic Therapy and Schema Therapy on Childhood Trauma in Women with Emotional Divorce. International Journal of Body, Mind and Culture, 13(9), Article e2026-1225. https://doi.org/10.61838/ijbmc.v13i9.1225

ABSTRACT

Objective: This study aimed to compare the effectiveness of short-term psychodynamic therapy and schema therapy on childhood trauma symptoms among women experiencing emotional divorce.

Methods and Materials: This quasi-experimental study used a pretest–posttest control-group design with a two-month follow-up. The participants were 45 women with emotional divorce who referred to counseling and psychology clinics in District 1 of Tehran in 2025. Participants were selected through purposive sampling and randomly assigned to three groups: short-term psychodynamic therapy, schema therapy, and control, with 15 participants in each group. The intervention groups received 15 sessions of intensive short-term dynamic psychotherapy and 8 sessions of schema therapy, respectively. Data were collected using the Emotional Divorce Questionnaire and Childhood Trauma Questionnaire. Repeated-measures analysis of variance and Bonferroni post hoc tests were used for data analysis.

Findings: The repeated-measures analysis showed significant effects of group, time, and time × group interaction on childhood trauma scores. The group effect was significant, $F = 9.32$, $p < .001$, $\eta^2 = .313$, and the time × group interaction was significant, $F = 7.62$, $p < .001$, $\eta^2 = .266$. Both short-term psychodynamic therapy and schema therapy significantly reduced childhood trauma compared with the control group. At posttest, the mean difference between short-term psychodynamic therapy and control was −3.26 ($p < .001$), and between schema therapy and control was −2.64 ($p = .005$). No significant difference was found between the two intervention groups ($p = 1.00$).

Conclusion: Short-term psychodynamic therapy and schema therapy were both effective in reducing childhood trauma among women experiencing emotional divorce, with no evidence of superiority of one approach over the other.

Keywords: Short-Term Psychodynamic Therapy, Schema Therapy, Childhood Trauma, Emotional Divorce, Women.

Introduction

The family is the smallest social unit and plays a very important role in the health and continuity of society (Dong et al., 2022). Emotional divorce should be considered a prelude to formal and legal divorce. Emotional divorce has many hidden and implicit dimensions, and extensive and precise studies are needed to examine and understand them. Emotional divorce can also affect various psychological factors, such as childhood trauma (Sadeghkhani et al., 2023). The existing clinical and empirical literature indicates the harmful and long-term consequences of interpersonal childhood trauma on couple functioning. It appears that experiences of violence and maltreatment in early life specifically affect survivors' ability to establish a lasting, intimate, and satisfying relationship (Alter et al., 2021). Complex childhood trauma includes physical abuse, sexual abuse, emotional abuse, emotional neglect, and physical neglect, which are inflicted on the child by caregivers or familiar individuals (Norman et al., 2012).

Many adults who experienced complex trauma in childhood have weaker communication skills and are unable to establish intimate relationships (Bigras et al., 2016). These individuals have less confidence and readiness for marriage, lower levels of relationship satisfaction and meaningful communication, and are more likely not to perceive their partner as caring (Nguyen et al., 2017). Women who suffer from chronic sexual, physical, and psychological violence often become caught in trauma; anxiety and fear surround their entire lives, and their trauma is reactivated by every trigger (Blasco-Ros et al., 2010). Women and men who have been exposed to complex trauma during childhood experience problems in marital relationships (Arroyo et al., 2026). The presence of negative emotions, excessive defenses, and negative automatic thoughts in the injured individual causes adaptive relationships with the spouse to reach a dead end (Romney et al., 2020). The behaviors of the traumatized individual lead to the formation of a negative interaction cycle between the individual and their spouse and result in increased distress in couple relationships (Riggs, 2019).

Considering that women, when faced with conflicts and disturbances in marital life, are emotionally and socially more vulnerable than men and have a stronger need for adaptive emotional relationships with their spouses, they often seek help from family specialists and counselors in order to preserve their married life when problems arise that lead to distress in their relationship. Various intervention methods have been used to improve psychological components in women with emotional divorce, including childhood trauma, conflict resolution, and psychological distress.

The short-term psychodynamic approach is one of the interventions that has been used for many psychological problems and has produced satisfactory results. Among the techniques used in short-term dynamic psychotherapy are the therapist's active stance and the proper application of techniques, which enable clients to identify the depth of their feelings and thoughts in the shortest possible time and achieve greater mental health (Town et al., 2017). Tactical defenses and specific intervention methods for neutralizing them are considered characteristics of short-term dynamic psychotherapy. Tactical defenses disrupt the process of developing deep and authentic understanding and reducing patients' irrational thoughts about others, while improving their satisfaction with life and with one another (Johansson & Lilliengren, 2026).

On the other hand, schema therapy is one of the therapeutic interventions used for women with cancer. From the perspective of Loose, schemas, which consist of thoughts, feelings, and memories, are formed when core emotional needs are not met, and they provide a way to explain past experiences and regulate future expectations (Edwards, 2022). Schemas represent an individual's view of the self and relationships with others and reflect the consistency of the early childhood environment. In fact, schemas are stored so that they can be activated under specific conditions (Roediger et al., 2018).

Given that each of these two therapeutic approaches has its own principles and techniques, the present study aims to compare the effectiveness of these two treatments on childhood trauma, conflict resolution, and psychological distress in women with emotional divorce. Since many women after emotional divorce face serious emotional, psychological, and social problems, evaluating the effectiveness of these treatments can provide valuable information for psychotherapists and mental health professionals and help design more effective and appropriate interventions for this group. In addition, this study can help identify effective treatments

for improving the quality of life and mental health of women after emotional divorce and can lay the groundwork for future research and therapeutic interventions in this field.

Methods and Materials

This study was applied in terms of purpose, and considering the aim and nature of the research, its design was quasi-experimental with a pretest–posttest control group design and a two-month follow-up period. The statistical population consisted of all women with emotional divorce who referred to counseling and psychology clinics licensed by the Organization of Counseling and Psychology in District 1 of Tehran during the first half of 2025, from April to September. To select the participants, the Emotional Divorce Questionnaire was first distributed among approximately 100 individuals referring to counseling and psychology centers in District 1 of Tehran, and women who obtained a score higher than 18 were invited to participate in the study. Forty-five individuals who met the inclusion criteria were selected as the sample and were randomly assigned, after matching in terms of age, gender, and other demographic variables, to three groups of 15 participants, including 30 participants in two experimental groups and 15 participants in one control group. The sampling method in the present study was non-random and purposive.

After selecting the sample, the topic, treatment courses, and their objectives were explained to the participants, and the ethical considerations of the study were also explained. After the end of the treatment period, the participants, as the statistical sample, completed the research questionnaires. During this period, the control group remained on the waiting list and no treatment was applied to them. Two months after the retest, the follow-up test was administered to the participants. The inclusion criteria were as follows: 1) informed consent, 2) obtaining a score higher than 18 on the Emotional Divorce Questionnaire, 3) minimum education at the diploma level, 4) minimum age of 20 and maximum age of 50, 5) no use of narcotics or alcohol, 6) not taking psychiatric medications, based on the participant's self-report, 7) absence of specific environmental or social conditions that could disrupt participation in the study, such as severe unemployment or family or social problems, 8) no participation in psychodynamic therapy, mentalization-based therapy, or other psychological treatments, and 9) ability to communicate and understand psychological content. The exclusion criteria included: 1) unwillingness to continue participation and 2) absence from more than three treatment sessions.

Instruments

1) Emotional Divorce Questionnaire

The Emotional Divorce Questionnaire was designed by Mohammadi et al. (2017). This scale consists of 36 items and includes the dimensions of criticism and blame, silence and defensiveness, emotional reaction, emotional intimacy, power and resources, loss and depression and frustration, third angle, restriction, and sexual problems. Each dimension includes 4 items and is scored on a five-point Likert scale ranging from never to always, with each item having a value between 1 and 4. It assesses emotional divorce with items such as: "My spouse and I consider each other the main cause of the problems in our life." This scale measures several dimensions of emotional divorce. A high score in emotional divorce or its dimensions indicates a higher level of emotional divorce and vice versa. The total score range is between 0 and 36. A higher score indicates greater emotional divorce. Therefore, a score higher than 18 on average for the total questionnaire and higher than 2 on average for each variable indicates above-average emotional divorce in marital life. In the study by Mohammadi et al. (2017), the validity of the questionnaire was confirmed by professors and experts in this field. In the study by Mohammadi et al. (2017), the reliability of the questionnaire was obtained using Cronbach's alpha, which was higher than 0.70. In the present study, the reliability of the questionnaire was calculated using Cronbach's alpha as 0.88.

2) Childhood Trauma Questionnaire (CTQ)

This questionnaire was designed by Bernstein et al. (2003). In 1995, the second 53-item version was presented, and finally, in 1998, the final 34-item version was developed. The questionnaire assesses childhood maltreatment in five subscales: physical abuse, emotional abuse, physical neglect, emotional neglect, and sexual abuse, and ultimately provides an overall abuse score. Items are answered on a five-point Likert scale ranging from never to always. Higher scores on the questionnaire indicate greater trauma or harm, and

lower scores indicate less trauma or harm during childhood. Bernstein et al. reported the concurrent validity of the questionnaire with therapists' ratings of childhood trauma in the range of 0.59 to 0.78. The reliability of this questionnaire was also obtained through test–retest and Cronbach's alpha methods in the range of 0.79 to 0.94. In the study by Ebrahimi et al., its construct validity was also confirmed, and the reliability coefficients of the total score and its subscales ranged from 0.81 to 0.97, indicating the desirable reliability of the questionnaire. In the present study, the reliability of the questionnaire was calculated using Cronbach's alpha as 0.93.

3) Short-Term Psychodynamic Therapy Protocol

Table 1 presents a summary of the sessions based on Davanloo (2001) Intensive Short-Term Dynamic Psychotherapy protocol (1995). This intervention was implemented in 15 sessions of 90 minutes.

Table 1

Sessions Based on Davanloo's Intensive Short-Term Dynamic Psychotherapy Protocol

Treatment sessions	Treatment content
1	In the first session, the rules for conducting treatment sessions are explained, and an initial interview is conducted using a dynamic sequence known as trial therapy to make an initial assessment of the participants' problems.
2	In the second session, if the participant responds appropriately to trial therapy, follow-up will be conducted. From this point, that is, from the second session onward, appropriate and effective interventions are implemented according to the ongoing movement among the triangle of conflict, the person, and the individual's 11 types of defenses. This process continues until the final sessions, depending on the types of defenses used by the individual. Common tactical defenses and effective interventions related to each are briefly presented below.
3	Working with tactical defenses, closed words, speaking indirectly or in vague language, inclusive-covering words; effective interventions: doubting, challenging, and challenging the defense.
4	Examining specialized words used by participants, tactical defenses of indirect speech, and pathological and hypothetical thoughts; effective intervention: challenging participants' defenses and doubting the defense.
5	Examining rumination and rationalization defenses; effective interventions respectively include clarification, requesting a definite response, doubting the defense, challenging the defense, and blocking the defense.
6	Defenses of intellectualization, generalization, and overgeneralization; effective interventions: clarification, blocking, challenge and specification, and challenging the defense.
7	Diversion tactics and forgetting; effective interventions: blocking the defense, doubting the defense, and challenging the defense.
8	Denial and negation; effective interventions: clarification, doubting the defense, and challenging the defense.
9	Externalization and ambiguity; effective interventions: clarification and challenging the defense.
10	Evasion and obsessive doubt; effective interventions: clarification and challenging the defense.
11	Somatization and acting out as defenses against feelings; effective intervention: clarification.
12	Rebellion, defiance, preamble-making, defensive crying, and the spectrum of regressive defenses; effective interventions: confrontation, challenge and direct engagement, and clarification.
13 and 14	Talking instead of touching feelings, nonverbal signs, compliance, and passivity; effective interventions: clarification, doubting the defense, challenging the defense, and clarifying the challenge.
15	Preparing to terminate therapy; focusing on feelings of loss in the context of ending therapy; termination of therapy and administration of the posttest.

4) Schema Therapy Protocol

This protocol was extracted based on the schema therapy book by Young et al., (2003) and was implemented in eight two-hour sessions, twice a week. The description and objectives of the sessions are presented in Table 2.

Table 2

Schema Therapy Protocol Based on Young et al. (2003)

Session	Session description
1	Introduction and establishment of rapport; administration of the pretest; explanation of the importance and purpose of schema therapy; formulation of clients' problems within the schema therapy approach.
2	Examination of objective evidence confirming or rejecting schemas based on current and past life evidence; discussion of the existing schema aspect in comparison with a healthy schema.
3	Introduction of schema domains and early maladaptive schemas; brief explanation of the biology of early maladaptive schemas; explanation of schema functions.
4	Introduction of maladaptive coping styles and responses that maintain schemas, along with examples from daily life; definition of the concept of schema modes; preparing patients for assessment and modification of schemas.
5	Preparing for change; assessment of schemas through the questionnaire; providing feedback to help identify schemas more clearly.
6	Training in experiential techniques, such as mental imagery of problematic situations and confrontation with the most problematic ones.

7	Training in relationships with significant others and role-playing; establishing dialogue between the healthy side and the schema side by patients; examining the advantages and disadvantages of healthy and unhealthy behaviors; providing strategies for overcoming barriers to behavioral change.
8	Brief review of previous sessions; presentation of learned strategies; practice; administration of the posttest.

Data Analysis

In the inferential findings section, the research hypotheses were tested, and the effectiveness of the short-term dynamic psychotherapy and schema therapy interventions on the dependent variable, namely childhood trauma, was examined using repeated-measures analysis of variance. In addition, the assumptions of parametric repeated-measures analysis of variance, including normal distribution of variables, homogeneity of variances, homogeneity of variance–covariance matrices, and homogeneity of error covariances, were examined using appropriate tests. Data analysis was performed using SPSS version 28.

Findings and Results

The demographic findings showed that the three groups were homogeneous in terms of educational level. The frequency of participants with lower-than-diploma and diploma education was higher than that of participants with university education. The significance level of the chi-square test was 0.765, which was higher than the 0.05 criterion, indicating that the three groups were similar in terms of educational level. The groups were also homogeneous in terms of the background variables of age and duration of marriage. The mean age ranged from 33.47 years in the control group to 34.33 years in the short-term psychodynamic therapy group. The mean duration of marriage ranged from a minimum of 7.67 years in the short-term psychodynamic therapy group to a maximum of 8.53 years in the control group. Table 3 describes the childhood trauma variable.

Table 3

Descriptive Statistics of Childhood Trauma by Group and Time

Variable	Time	Short-term psychodynamic therapy Mean	Short-term psychodynamic therapy SD	Schema therapy Mean	Schema therapy SD	Control Mean	Control SD
Childhood trauma	Pretest	58.20	7.97	61.47	12.37	63.07	9.95
Childhood trauma	Posttest	54.80	7.59	58.60	12.34	62.80	10.18
Childhood trauma	Follow-up	55.33	8.16	58.40	12.50	63.67	10.28

Table 3 showed that the mean score of childhood trauma in the short-term psychodynamic therapy group was 58.20 at pretest, which decreased to 54.80 and 55.33 at posttest and follow-up, respectively, indicating a reduction in the mean score of childhood trauma. In the schema therapy group, the pretest mean was 61.47, and the posttest and follow-up means were 58.60 and 58.40, respectively, indicating a reduction in the mean score at posttest and follow-up. In the control group, the mean score of childhood trauma did not show a considerable change compared with the intervention groups.

The results of the Shapiro–Wilk test for assessing the normality of the research variables indicated that the distribution of childhood trauma was normal in all three groups; therefore, the normality assumption was confirmed. The significance level of the Shapiro–Wilk test for all variables at the three times of pretest, posttest, and follow-up was higher than the 0.001 criterion ($p > 0.001$). According to the findings, the assumption of normal distribution of the variable was confirmed. The results of Levene's test showed that the significance level of Levene's test ranged from a minimum of 0.172 for the conflict resolution variable to a maximum of 0.396 for the childhood trauma variable. Given that the obtained significance level was higher than the 0.05 criterion, it can be concluded that the variance of childhood trauma was homogeneous across the groups, and the assumption of homogeneity of variances was met ($p > 0.05$). The results of Box's M test showed that the assumption of homogeneity of variance–

covariance matrices for childhood trauma was confirmed ($p > 0.001$). The obtained significance level was at least 0.007 for conflict resolution, indicating homogeneity of the variables, and the assumption of homogeneity of variance–covariance matrices was met. The results of Mauchly's test showed that, given the obtained significance level for childhood trauma, which was higher than the 0.001 criterion, the assumption of homogeneity of error covariances for the variables of childhood trauma, conflict resolution, and psychological distress was confirmed ($p > 0.001$).

To test the hypothesis, repeated-measures analysis of variance was used. Table 4 presents the between-subjects effects, group effect, within-subjects effect, time effect, and the interaction effect of time and group.

Table 4

Repeated-Measures Test for Examining the Effectiveness of the Groups and Comparing Them on Childhood Trauma

Variable	Source of effect	Sum of squares	df	Mean square	F	p-value	Partial eta squared
Childhood trauma	Group	87.07	2	43.54	9.32	<0.001	0.313
Childhood trauma	Time	120.95	2	60.47	25.05	<0.001	0.374
Childhood trauma	Time × Group	73.58	4	18.40	7.62	<0.001	0.266

The results in Table 4 regarding childhood trauma showed that all three sources of effect, including group effect, time effect, and the interaction effect of time and group, were significant ($p < 0.05$). The findings indicated that, since the interaction effect of time and group was significant as the most important source of effect, the effectiveness of at least one of the interventions on childhood trauma was statistically confirmed. Given the confirmation of the interaction effect of time and group, which is the most important effect, pairwise comparisons were examined. In Table 5, the mean score of childhood trauma at posttest, controlling for the pretest score, and at follow-up, controlling for the pretest score, is compared among the three groups.

Table 5

Adjusted Means of Childhood Trauma at Posttest and Follow-Up Controlling for Pretest Score

Variable	Time	Group	Adjusted posttest/follow-up mean	Standard error
Childhood trauma	Posttest	Short-term psychodynamic therapy	57.44	0.565
Childhood trauma	Posttest	Schema therapy	58.06	0.558
Childhood trauma	Posttest	Control	60.70	0.562
Childhood trauma	Follow-up	Short-term psychodynamic therapy	58.03	0.609
Childhood trauma	Follow-up	Schema therapy	57.85	0.601
Childhood trauma	Follow-up	Control	61.52	0.606

The examination of the adjusted means in Table 5 showed that the lowest posttest mean belonged to the short-term psychodynamic therapy group, with a value of 57.44, and the mean of the schema therapy group was 58.06. The highest mean belonged to the control group, with a value of 60.70. At follow-up, the lowest mean belonged to the schema therapy group, and the highest mean belonged to the control group. Table 6 presents the results of the Bonferroni post hoc test for examining and comparing the effectiveness of the interventions.

Table 6

Bonferroni Post Hoc Test for Examining the Effectiveness of the Interventions and Comparing Their Effectiveness on Childhood Trauma

Variable	Time	Reference group	Comparison group	Mean difference	Standard error	p-value
Childhood trauma	Posttest	Short-term psychodynamic therapy	Control	-3.26	0.805	<0.001
Childhood trauma	Posttest	Schema therapy	Control	-2.64	0.791	0.005
Childhood trauma	Posttest	Short-term psychodynamic therapy	Schema therapy	-0.62	0.796	1.00
Childhood trauma	Follow-up	Short-term psychodynamic therapy	Control	-3.49	0.867	<0.001
Childhood trauma	Follow-up	Schema therapy	Control	-3.67	0.852	<0.001
Childhood trauma	Follow-up	Short-term psychodynamic therapy	Schema therapy	0.19	0.858	1.00

The results of the Bonferroni post hoc test in Table 6 regarding childhood trauma showed a significant difference between the intervention groups and the control group at posttest ($p < 0.05$). The posttest mean of the short-term psychodynamic therapy group was 3.26 points lower than that of the control group, and the posttest mean of the schema therapy group was 2.64 points lower than that of the control group. Since the means of the two intervention groups were lower than that of the control group, it can be concluded that the effectiveness of both short-term psychodynamic therapy and schema therapy on childhood trauma was confirmed ($p < 0.05$). Both interventions reduced childhood trauma among the participants.

The comparison of the two interventions in terms of effectiveness showed no significant difference between short-term psychodynamic therapy and schema therapy on childhood trauma ($p > 0.05$). The mean difference was 0.62, and the significance level was higher than the 0.05 criterion, indicating that the effectiveness of the two intervention methods, short-term psychodynamic therapy and schema therapy, on childhood trauma was equal. The results of the Bonferroni post hoc test at follow-up, shown in Table 6, indicated that, similar to the posttest stage, there was a significant difference between the intervention groups and the control group in the follow-up mean ($p < 0.05$). The follow-up mean of the short-term psychodynamic therapy group was 3.49 points lower than that of the control group, and the follow-up mean of the schema therapy group was 3.67 points lower than that of the control group. Since the means of the two intervention groups were lower than that of the control group, it can be inferred that the durability of the effects of short-term psychodynamic therapy and schema therapy on childhood trauma was confirmed. Table 7 presents the results of pairwise mean comparisons within each group.

Table 7

Pairwise Comparison of the Mean Scores of Childhood Trauma Within Each Group

Variable	Group	Reference time	Comparison time	Mean difference	Standard error	p-value
Childhood trauma	Short-term psychodynamic therapy	Pretest	Posttest	3.40	0.682	<0.001
Childhood trauma	Short-term psychodynamic therapy	Pretest	Follow-up	2.87	0.601	<0.001
Childhood trauma	Short-term psychodynamic therapy	Posttest	Follow-up	-0.53	0.703	0.461
Childhood trauma	Schema therapy	Pretest	Posttest	2.87	0.568	<0.001
Childhood trauma	Schema therapy	Pretest	Follow-up	3.07	0.565	<0.001
Childhood trauma	Schema therapy	Posttest	Follow-up	0.20	0.416	0.638
Childhood trauma	Control	Pretest	Posttest	0.27	0.371	0.484
Childhood trauma	Control	Pretest	Follow-up	-0.60	0.616	0.346
Childhood trauma	Control	Posttest	Follow-up	-0.87	0.496	0.103

The post hoc test results in Table 7 regarding childhood trauma showed that, in the intervention groups, there was a significant change in the posttest and follow-up means compared with the pretest mean. This indicated that the means of both the short-term psychodynamic therapy and schema therapy groups decreased at posttest and follow-up compared with pretest ($p < 0.05$). Examination of the durability of the effect through comparison of the follow-up mean with the pretest and posttest means showed that the follow-up mean was significantly lower than the pretest mean, but it did not differ significantly from the posttest mean. Therefore, the durability of the effects of short-term psychodynamic therapy and schema therapy on childhood trauma was confirmed. In the control group, the means across time did not differ significantly ($p > 0.05$).

Discussion and Conclusion

The results showed that the effectiveness of both short-term psychodynamic therapy and schema therapy on childhood trauma was confirmed, and both interventions reduced childhood trauma among the participants. In addition, comparison of the two interventions in terms of effectiveness showed no significant difference between short-term psychodynamic therapy and schema therapy on childhood trauma. Therefore, there was no difference between the effectiveness of short-term psychodynamic therapy and schema therapy on childhood trauma in women with emotional divorce. In other words, the first

hypothesis of the study was not confirmed. These findings are consistent with the results of Lian et al. (2024), who emphasized the power of schema therapy in repairing repeated traumas, as well as with the findings of Balali Dehkordi & Fatehizade (2022), who confirmed the effectiveness of psychodynamic and depth-oriented therapies on complex childhood trauma. However, from the perspective of equal effectiveness, this result is implicitly inconsistent with some studies that have reported the superiority of a specific approach in trauma treatment protocols, although there is a high level of theoretical agreement in the research literature regarding the overall effectiveness of both methods.

The findings obtained from testing the research hypothesis, indicating the equal effectiveness of short-term psychodynamic therapy and schema therapy in reducing symptoms of childhood trauma among women experiencing emotional divorce, have important theoretical and clinical implications rooted in the structural similarities of these two approaches in dealing with developmental experiences. From a theoretical perspective, both treatment models are based on the assumption that early childhood adversities and traumas form the main foundation of psychological dysfunctions and interpersonal problems in adulthood. In short-term psychodynamic therapy, the focus is on identifying repetitive patterns rooted in early object relations, where childhood traumas are represented through the mechanism of "repetition compulsion" in the form of emotional divorce and current relational impasses. In contrast, schema therapy, by focusing on "early maladaptive schemas," views the same injuries as stable cognitive-emotional structures formed as a result of unmet core emotional needs. The absence of a significant difference between these two approaches indicates that, despite differences in therapeutic techniques, both interventions focus on a common goal: "enhancing insight into the past" and "emotional processing of trauma." This is consistent with recent research findings in the field of common therapeutic factors.

In explaining the similar effectiveness of these approaches, the role of "therapeutic alliance" and "reviewing past experiences" can be emphasized, as both are considered the backbone of treatment in these approaches. In psychodynamic therapy, the client gains access to the unconscious roots of trauma through the analysis of transference and confrontation with psychological defenses. In schema therapy, techniques such as "limited reparenting" and "imagery rescripting" target exactly the same traumatic content. Recent international studies, including the research by Putica et al. (2023), emphasize that when psychological interventions focus on emotion regulation and reconstruction of the meaning of painful experiences, differences in theoretical orientation, whether psychodynamic or schema-focused, have less impact than the depth of emotional processing. In fact, women with emotional divorce in this study were able, through both therapies, to identify the connection between their inner "wounded child" and their current "helpless adult." This process led to a reduction in the emotional burden of accumulated traumas and consequently improved their psychological condition. It seems that both therapies, through different paths, guided the clients toward the same destination: "self-compassion" and "breaking the chain of trauma."

Furthermore, the demographic characteristics and cultural context of clients in District 1 of Tehran may have played a considerable role in explaining the absence of a difference between the two therapies. Women referring to clinics in this district often have higher levels of education and self-awareness, which may increase "therapeutic receptiveness" in both models. According to Garner & Kleiman (2025) theory of distress tolerance (2025), individuals with higher cognitive capacity show greater ability to reprocess traumatic information when exposed to deep interventions, whether through object relations analysis or empty-chair techniques. Therefore, the effectiveness of both therapies on childhood trauma in this specific group may depend less on specific techniques and more on the client's psychological readiness to enter deeper psychological layers. This finding is consistent with domestic studies, including the research by Vejdani et al. (2025), which emphasized the importance of emotion regulation as a key variable in reducing persistent injuries, because both treatments directly or indirectly empower patients to manage emotions arising from trauma.

In addition, the lack of superiority of one method over the other can be explained through the concept of "conceptual overlap." Many concepts in schema therapy, such as schema modes, are in fact modern and structured reinterpretations of classical psychodynamic concepts,

such as internalized objects. Therefore, when the psychodynamic therapist focuses on resolving internal conflicts arising from trauma, they are essentially changing the same structures that Jeffrey Young refers to as schemas. Roediger et al. (2018) also emphasized in their analyses that, in trauma treatment, what is crucial is the creation of a "safe space" for recounting painful narratives; a space that is effectively provided in both treatment protocols. Therefore, the absence of a significant difference between the two methods does not indicate their weakness, but rather their "equivalent capacity" to penetrate the defensive layers of women affected by emotional divorce and repair their developmental wounds.

Considering that the statistical population of this study was limited exclusively to women in District 1 of Tehran, caution should be exercised in generalizing the results to women in other districts of Tehran, other cities, or different socioeconomic classes, because the cultural and welfare characteristics of clients in this district may influence their response to treatment. This study was also conducted only on women; therefore, its findings are not necessarily generalizable to men who are experiencing emotional divorce or facing similar challenges in couple relationships. It is recommended that future studies implement these interventions among men experiencing emotional divorce and also among couples simultaneously, so that gender-based comparisons of effectiveness can be made. In addition, conducting similar studies in different geographical regions and cultural-economic contexts, including lower-income urban areas and smaller cities, can help examine the role of social variables in responsiveness to depth-oriented therapies. Finally, it is recommended that mental health specialists and trauma therapists confidently use both approaches when working with clients whose marital problems are rooted in developmental injuries and adverse childhood experiences. Family specialty clinics are also advised to prioritize training in these two treatment models in their therapists' continuing education programs so that they can deeply repair clients' personality foundations.

Acknowledgments

The authors express their gratitude and appreciation to all participants.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Declaration of Helsinki, which provides guidelines for ethical research involving human participants. Ethical considerations in this study were that participation was entirely optional.

Transparency of Data

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

Funding

This research was carried out independently, with personal funding, and without financial support from any governmental or private institution or organization.

Authors' Contributions

All authors equally contributed to this study.

References

Alter, S., Wilson, C., Sun, S., Harris, R. E., Wang, Z., Vitale, A., Hazlett, E. A., Goodman, M., Ge, Y., & Yehuda, R. (2021). The association of childhood trauma with sleep disturbances and risk of suicide in US veterans. *Journal of psychiatric research*, *136*, 54-62. https://doi.org/10.1016/j.jpsychires.2021.01.030

Arroyo, A., Richardson, E. W., Futris, T. G., Brown, R. A., & Gilbert, A. S. (2026). Adverse Childhood Experiences, Psychosocial Problems, and Relationship Quality in Romantic Couples: Relationship Maintenance Skills as an Interpersonal Resource. *Journal of Social and Personal Relationships*, 02654075261445143. https://doi.org/10.1177/02654075261445143

Balali Dehkordi, N., & Fatehizade, M. (2022). Comparison of the effectiveness of Emotion-focused Therapy and Intensive short-term dynamic psychotherapy on marital adjustment of married women with experience of complex childhood trauma. *Counseling and psychotherapy culture*, *13*(51), 31-57. https://doi.org/10.22054/qccpc.2022.65682.2871

Bernstein, D. P., Stein, J. A., Newcomb, M. D., Walker, E., Pogge, D., Ahluvalia, T., Stokes, J., Handelsman, L., Medrano, M., & Desmond, D. (2003). Development and validation of a brief screening version of the Childhood Trauma Questionnaire. *Child abuse & neglect*, *27*(2), 169-190. https://doi.org/10.1016/S0145-2134(02)00541-0

Bigras, N., Godbout, N., & Dugal, C. (2016). Childhood interpersonal trauma and its repercussions in adulthood: An analysis of psychological and interpersonal sequelae. *A multidimensional approach to post-traumatic stress disorder-from theory to practice*. 10.5772/64476

Blasco-Ros, C., Sánchez-Lorente, S., & Martinez, M. (2010). Recovery from depressive symptoms, state anxiety and post-traumatic stress disorder in women exposed to physical and psychological, but not to psychological intimate partner violence alone: A longitudinal study. *BMC psychiatry*, *10*(1), 98. https://doi.org/10.1186/1471-244X-10-98

Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of abnormal child psychology*, *31*(1), 41-53. https://doi.org/10.1023/A:1021769215342

Davanloo, H. (2001). Intensive short-term dynamic psychotherapy: extended major direct access to the unconscious. *European Psychotherapy*, *2*(2), 25-70. doi: 10.7717/peerj.548

Dong, S., Dong, Q., & Chen, H. (2022). Mothers' parenting stress, depression, marital conflict, and marital satisfaction: The moderating effect of fathers' empathy tendency. *Journal of affective disorders*, *299*, 682-690. https://doi.org/10.1016/j.jad.2021.12.079

Edwards, D. J. A. (2022). Using schema modes for case conceptualization in schema therapy: An applied clinical approach. *Frontiers in psychology*, *12*, 763670. https://doi.org/10.3389/fpsyg.2021.763670

Garner, R. C., & Kleiman, E. M. (2025). Distress tolerance as a moderator of affective forecasting effects. *Affective science*, *6*(2), 280-284. https://doi.org/10.1007/s42761-025-00303-2

Johansson, R., & Lilliengren, P. (2026). Effectiveness and mechanisms of Intensive Short-Term Dynamic Psychotherapy for treatment-resistant depression: a reanalysis of a randomized controlled trial. *Frontiers in Psychiatry*, *17*, 1815946. https://doi.org/10.3389/fpsyt.2026.1815946

Lian, A. E. Z., Chooi, W.-T., & Bono, S. A. (2024). The development and the effectiveness of schema therapy on Malaysian female young adults who experienced continuous trauma and post-traumatic stress disorder. *European Journal of Trauma & Dissociation*, *8*(3), 100427. https://doi.org/10.1016/j.ejtd.2024.100427

Mohammadi, F., Jokar, K. M., & Golestaneh, M. (2017). Construction, Factor Analysis And Standardization Of The Emotional Divorce Questionnaire. https://sid.ir/paper/262276/en

Nguyen, T. P., Karney, B. R., & Bradbury, T. N. (2017). Childhood abuse and later marital outcomes: Do partner characteristics moderate the association? *Journal of family psychology*, *31*(1), 82. https://doi.org/10.1037/fam0000208

Norman, R. E., Byambaa, M., De, R., Butchart, A., Scott, J., & Vos, T. (2012). The long-term health consequences of child physical abuse, emotional abuse, and neglect: a systematic review and meta-analysis. *PLoS medicine*, *9*(11), e1001349. https://doi.org/10.1371/journal.pmed.1001349

Putica, A., O'Donnell, M. L., Felmingham, K. L., & Van Dam, N. T. (2023). Emotion response disconcordance among trauma-exposed adults: The impact of alexithymia. *Psychological medicine*, *53*(12), 5442-5448. https://doi.org/10.1017/S0033291722002586

Riggs, S. A. (2019). Childhood emotional abuse and the attachment system across the life cycle: What theory and research tell us. In *The effect of childhood emotional maltreatment on later intimate relationships* (pp. 5-51). Routledge. https://doi.org/10.4324/9781315874920-2

Roediger, E., Stevens, B. A., & Brockman, R. (2018). *Contextual schema therapy: An integrative approach to personality disorders, emotional dysregulation, and interpersonal functioning*. New Harbinger Publications. https://psycnet.apa.org/record/2018-30793-000

Romney, J., Austin, K., Fife, S. T., Sanders, D., & Snyder, H. (2020). Stress experienced and meaning-making of couples with children with autism spectrum disorder: A phenomenological study. *The American Journal of Family Therapy*, *49*(1), 37-56. https://doi.org/10.1080/01926187.2020.1813654

Sadeghkhani, M., Emamipour, S., & Mirhashemi, M. (2023). Compilation of the structural model of emotional divorce based on the dark triple traits of personality and conflict resolution styles. *Journal of Assessment and Research in Applied Counseling*. https://doi.org/10.61838/kman.jarac.5.3.1

Town, J. M., Salvadori, A., Falkenström, F., Bradley, S., & Hardy, G. (2017). Is affect experiencing therapeutic in major depressive disorder? Examining associations between affect experiencing and changes to the alliance and outcome in intensive short-term dynamic psychotherapy. *Psychotherapy*, *54*(2), 148. https://doi.org/10.1037/pst0000108

Vejdani, N., Ahmadian, H., Yarahmadi, Y., & Karimi, Q. (2025). Comparison of the effectiveness of an empowerment-based educational program and emotion-focused therapy on resilience and emotion regulation in women experiencing domestic violence. *International Journal of Education and Cognitive Sciences*, *6*(1), 67-80. https://doi.org/10.61838/kman.ijecs.6.1.7

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide* (Vol. 44). guilford press New York. https://www.guilford.com/books/Schema-Therapy/Young-Klosko-Weishaar/9781593853723?srsltid=AfmBOopEZLH5jxRs2J2o9syCb-uWiFZlIFTBUm56EaRJkdpPAq_-puPF