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Comparison of the Effectiveness of Schema Therapy and Emotionally Focused Therapy (EFT) on Increasing Empathy and Reducing Symptoms of Marital Depression in Couples

Hatam. Siavoshi[1], Davood. Kordestani[2*]

1 PhD student, Department of Psychology, Bo.C., Islamic Azad University, Borujerd, Iran
2 Associate Professor, Department of Psychology, Tehran Branch, Payame Noor University, Tehran, Iran
*Correspondence: Kordestani3000@pnu.ac.ir

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ABSTRACT

The present study was conducted to compare the effectiveness of schema therapy and Emotionally Focused Therapy (EFT) on empathy and symptoms of marital depression in couples. The research method was quasi-experimental with a pretest-posttest and follow-up design including two experimental groups and one control group. The sample of the present study consisted of 60 couples from the city of Hamadan who were selected through purposive sampling and assigned to three groups of 20 participants each. Subsequently, two groups were randomly assigned as experimental groups and one group as the control group. Standardized questionnaires were used in this study. After considering the assumptions of statistical analysis, the data were analyzed using repeated measures analysis of variance and Bonferroni post hoc test. The findings indicated that there was a significant difference between the schema therapy group and the Emotionally Focused Therapy (EFT) group compared with the control group in the variables of empathy and depressive symptoms ($p < .05$). Furthermore, a significant difference was observed between the schema therapy experimental group and the Emotionally Focused Therapy experimental group based on the mean scores of the variables in the posttest and follow-up stages ($p < .05$). The results demonstrated that schema therapy was more effective than Emotionally Focused Therapy in increasing empathy, whereas Emotionally Focused Therapy was more effective than schema therapy in reducing symptoms of depression.

Keywords: effectiveness, schema therapy, Emotionally Focused Therapy (EFT), empathy, depressive symptoms, couples

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Introduction

Marital relationships constitute one of the most important interpersonal contexts for emotional regulation, psychological security, mutual support, and the formation of adaptive patterns of intimacy. The quality of marital interaction is shaped not only by observable communication behaviors but also by deeper cognitive, emotional, and relational structures that influence how partners perceive themselves, interpret one another's behaviors, respond to conflict, and regulate emotional distress. In distressed couples, relational dissatisfaction often appears through reduced emotional responsiveness, impaired empathy, recurrent misunderstandings, defensive interactional cycles, emotional withdrawal, and symptoms of

depression. From a psychological perspective, marital problems may therefore be understood as the outcome of both intrapsychic vulnerabilities and interpersonal processes, especially when maladaptive schemas, emotion dysregulation, and insecure emotional bonds interfere with partners' ability to understand and respond to each other's emotional needs (1-3).

Empathy is a central construct in couple functioning because it enables spouses to perceive, understand, and respond to each other's emotional states. In marital relationships, empathy is not limited to cognitive perspective-taking; rather, it includes affective resonance, emotional attunement, compassionate responsiveness, and the ability to recognize the partner's attachment needs during conflict. When empathy is weakened, couples are more likely to interpret each other's behaviors through defensive assumptions, personalize disagreements, and react with criticism, avoidance, or emotional distancing. Previous studies have emphasized that emotional empathy is strongly related to marital satisfaction, relational adjustment, and the reduction of destructive interaction patterns (4, 5). In couples with marital conflicts, interventions that directly target emotional expression, validation, and empathic responsiveness can improve cognitive-affective empathy and increase the couple's capacity to repair relational ruptures (3).

Depressive symptoms are also highly relevant to marital functioning. Depression can reduce emotional availability, increase negative cognitive bias, impair problem-solving, and intensify withdrawal or irritability in intimate relationships. In couples, depressive symptoms may become embedded in reciprocal patterns in which one partner's emotional distress decreases responsiveness and the other partner reacts with criticism, helplessness, or disengagement. The relationship between depression and maladaptive cognitive-emotional patterns has been documented in different clinical and nonclinical populations. Studies have shown that depression is associated with dysfunctional cognitive schemas, personality vulnerabilities, emotion dysregulation, and maladaptive patterns of self-evaluation (6-8). Therefore, couple-based psychological interventions should address not only the interpersonal manifestations of distress but also the underlying emotional and cognitive mechanisms that maintain depressive symptoms within the relationship.

One of the major theoretical frameworks for understanding persistent emotional and relational problems is schema theory. Early maladaptive schemas are deep, enduring cognitive-emotional patterns that develop when basic emotional needs are not adequately met during childhood and adolescence. These schemas shape individuals' expectations about themselves, others, and relationships, and they often become activated in intimate partnerships where attachment needs, vulnerability, rejection sensitivity, and dependency concerns are highly salient. In distressed couples, schemas such as abandonment, mistrust, emotional deprivation, defectiveness, subjugation, and unrelenting standards may lead partners to misinterpret ordinary relational difficulties as signs of rejection, betrayal, inadequacy, or emotional danger. Research has indicated that early maladaptive schemas play an important role in emotional divorce, emotion regulation difficulties, marital forgiveness, and depressive vulnerability (1, 2, 7).

Schema therapy is an integrative therapeutic approach that combines cognitive, behavioral, experiential, attachment-based, and psychodynamic techniques to modify early maladaptive schemas and replace maladaptive coping responses with healthier emotional and interpersonal patterns. In the context of couple relationships, schema therapy can help partners identify their own activated schemas, understand the developmental origins of their emotional reactions, recognize maladaptive coping modes, and respond to marital conflict from a healthier adult mode. This approach is particularly relevant when couples repeatedly

experience intense emotional reactions that are disproportionate to current events but meaningful in light of past relational injuries and unmet emotional needs. Evidence suggests that schema therapy can improve cognitive avoidance, anxiety, empathy, cognitive emotion regulation, and emotional behavior regulation in different populations (9-11). Moreover, studies on clinical depression have shown that schema therapy may be effective in reducing depressive symptoms, particularly when depression is comorbid with enduring personality patterns or maladaptive cognitive structures (8, 12).

The connection between schemas and empathy is especially important in couple therapy. When a partner's maladaptive schema is activated, the person may respond from a defensive coping mode rather than from empathic awareness. For example, a spouse with abandonment schema may interpret temporary emotional distance as rejection, while a spouse with defectiveness schema may perceive criticism even in neutral feedback. Such schema activation can reduce the ability to accurately understand the partner's emotions and intentions. Prior research has shown that emotional schemas and resilience can predict perceived empathy, suggesting that deeper emotional-cognitive structures influence empathic functioning (13). In addition, schema therapy has been found to influence empathy-related outcomes among married women and couples, indicating that schema modification may increase partners' capacity for emotional understanding and responsiveness (9, 10).

Emotionally Focused Therapy (EFT) provides another major evidence-informed framework for treating couple distress. EFT is based on attachment theory and emphasizes the restructuring of negative emotional interaction cycles through the identification, expression, and transformation of primary emotions and unmet attachment needs. Unlike approaches that focus mainly on communication skills, EFT views marital conflict as a pattern organized around emotional insecurity and attachment threat. In this model, anger, criticism, withdrawal, and defensiveness are often secondary responses that conceal deeper emotions such as fear, sadness, shame, loneliness, and the need for closeness. By helping partners access and communicate vulnerable emotions, EFT aims to create new cycles of emotional engagement, secure bonding, and empathic responsiveness. Studies have shown that EFT-based interventions can improve marital satisfaction, emotional empathy, marital empathy, and emotional regulation among couples (3-5).

EFT may also be particularly useful for reducing depressive symptoms because it directly targets emotional processing, relational security, and dysregulated affective patterns. Depression often involves emotional suppression, hopelessness, disconnection, and difficulty communicating core needs. EFT encourages individuals to identify and express primary emotions and to receive validating responses from their partners, which may reduce isolation and increase emotional support. Recent studies have reported the effectiveness of emotion-focused therapy on emotion dysregulation, resilience, depression-related variables, and psychological symptoms across different clinical groups (14, 15). Research comparing narrative therapy and EFT has also highlighted the relevance of EFT for reducing depression and maladaptive schemas in vulnerable student populations with suicidal thoughts (16). These findings support the broader assumption that emotional processing and attachment-based responsiveness can reduce depressive symptoms by improving the emotional environment in which distress is experienced and regulated.

Comparative research on schema therapy and EFT is important because both approaches address emotional distress but do so through different mechanisms. Schema therapy focuses more explicitly on early

maladaptive schemas, coping modes, developmental origins, and cognitive-emotional restructuring, whereas EFT focuses on present relational cycles, attachment emotions, and corrective emotional experiences between partners. In depression, schema therapy may be especially useful when symptoms are maintained by rigid self-beliefs, maladaptive cognitive patterns, and early emotional deprivation. EFT may be especially useful when depressive symptoms are maintained by relational disconnection, emotional suppression, and lack of secure attachment responsiveness. Previous comparative evidence suggests that both schema therapy and EFT can improve optimism, meaning in life, depression-related outcomes, and emotional functioning in individuals with major depressive disorder (17). However, more couple-focused comparative research is needed to clarify whether these approaches differ in their effects on empathy and depressive symptoms in marital contexts.

The empirical literature also indicates that maladaptive schemas are not limited to psychiatric populations but appear across medical, family, and relational contexts. For example, early maladaptive schemas have been examined in patients with inflammatory bowel disease, highlighting the role of schema-based psychological needs in populations experiencing chronic stress and psychotherapeutic needs (18). Similar mechanisms may operate in marital distress, where emotional vulnerability and relational stress repeatedly activate old schema patterns. Localized schema therapy models have also been developed and evaluated, suggesting that cultural adaptation and contextual sensitivity are important when applying schema-based interventions in Iranian clinical and counseling settings (19). These findings are relevant because marital expectations, emotional expression, gender roles, and help-seeking behaviors may be shaped by cultural context, and couple interventions should be evaluated within the social and cultural environment in which they are applied.

Another important point is that marital depression and empathy deficits may reinforce each other. When depressive symptoms increase, spouses may become less emotionally responsive, less motivated to engage in repair attempts, and more likely to interpret relational events negatively. At the same time, reduced empathy may intensify feelings of loneliness, rejection, and hopelessness, thereby worsening depressive symptoms. Emotion regulation has been identified as a mediator in the relationship between maladaptive schemas and emotional divorce, which suggests that cognitive-emotional vulnerabilities may influence marital outcomes through impaired regulation and reduced emotional responsiveness (1). Similarly, the role of resilience in the relationship between personality, early maladaptive schemas, marital forgiveness, and depression indicates that adaptive psychological resources can buffer the negative relational impact of schema-driven distress (2). Therefore, interventions that increase empathic responsiveness and reduce depressive symptoms may have reciprocal benefits for marital functioning.

In recent years, psychological interventions have increasingly emphasized transdiagnostic and process-based mechanisms such as emotion regulation, cognitive schemas, resilience, alexithymia, and interpersonal responsiveness. Emotion-focused therapy has shown promising effects on emotion dysregulation and resilience among patients with chronic pain and depressive symptoms, demonstrating that emotional processing can produce clinically meaningful improvements beyond traditional symptom reduction (14). Similarly, comparative studies of EFT and yoga therapy have shown effects on physical symptoms and alexithymia in depressed women, suggesting that interventions addressing emotional awareness and expression can improve psychological and somatic manifestations of depression (15). These findings

strengthen the rationale for examining EFT in couples where emotional avoidance, suppression, and disconnection are central to relational distress.

Schema therapy has also received growing empirical attention in depression research. Randomized clinical evidence has compared schema therapy with cognitive behavioral therapy and supportive therapy in inpatient and day clinic settings, indicating that schema-focused interventions are relevant for depressive disorders and may be particularly important when depression is embedded in persistent cognitive-personality patterns (8). Other randomized evidence has examined dosage effects of psychodynamic and schema therapy in individuals with comorbid depression and personality disorder, further supporting the clinical significance of schema-level interventions for complex depression (12). In family and educational contexts, group schema therapy has been associated with improvements in cognitive emotion regulation and emotional behavior regulation, suggesting that schema-based work may strengthen individuals' capacity to manage emotional reactions in interpersonal contexts (11).

Despite these advances, several gaps remain in the literature. First, many studies have examined either schema therapy or EFT separately, while fewer studies have directly compared their effects within the same couple-based research design. Second, previous studies have often focused on general marital satisfaction, emotion regulation, or depression, whereas fewer have simultaneously examined empathy and depressive symptoms as two interrelated outcomes in couples. Third, although studies have shown that EFT can improve marital empathy and that schema therapy can influence empathy-related variables, it is still unclear whether schema therapy or EFT is more effective for increasing empathy among couples experiencing marital distress (3, 4, 10). Fourth, given that depressive symptoms may be maintained by both cognitive schemas and emotional disconnection, direct comparison of schema therapy and EFT can clarify whether cognitive-schema restructuring or attachment-based emotional processing produces stronger effects on depressive symptoms.

In the context of Iranian couples referring to counseling centers, this comparison is especially important because marital distress often involves complex interactions among family expectations, emotional communication patterns, unresolved conflicts, and cultural norms regarding intimacy and emotional expression. Schema therapy may help couples recognize how their early experiences and maladaptive schemas shape present relational reactions, while EFT may help them restructure emotional cycles and communicate vulnerable attachment needs more effectively. Prior studies in Iranian samples have supported the usefulness of schema therapy for cognitive avoidance, anxiety, and empathy in couples and married women, as well as the usefulness of EFT-based interventions for marital empathy, emotional dysregulation, and relational outcomes (5, 9, 10). However, a direct comparison of these two interventions on empathy and depressive symptoms can provide more precise evidence for clinicians selecting treatment protocols for couples with marital difficulties.

Overall, the theoretical and empirical literature suggests that schema therapy and EFT may both be effective, but potentially through different pathways. Schema therapy may increase empathy by helping partners identify schema-driven distortions, reduce maladaptive coping modes, and respond from the healthy adult mode. It may reduce depressive symptoms by modifying negative self-beliefs, emotional deprivation schemas, and chronic cognitive patterns associated with hopelessness and inadequacy. EFT may increase empathy by facilitating emotional attunement, validation, and responsiveness to attachment needs.

It may reduce depressive symptoms by increasing emotional connection, decreasing isolation, and transforming negative interaction cycles into secure relational patterns. Given the growing evidence for both approaches in depression, empathy, emotion regulation, and marital functioning, a comparative study can contribute to intervention selection and the development of more targeted couple therapy protocols (14, 16, 17).

The aim of the present study was to compare the effectiveness of schema therapy and Emotionally Focused Therapy (EFT) in increasing empathy and reducing symptoms of marital depression among couples.

Methods and Materials

Study Design and Participants

The present study employed a quasi-experimental design with pretest, posttest, and follow-up assessments, including two experimental groups and one control group. The statistical population consisted of all couples referring to family counseling centers in the city of Hamadan during the first quarter of 2025 for counseling services, totaling 180 individuals. To determine the sample size, 118 individuals (estimated based on Morgan's table) were purposively selected from among the 180 clients attending family counseling centers in Hamadan and completed the Marital Conflict Questionnaire. Subsequently, based on the questionnaire cutoff scores (scores ranging from 162 to 270), eligible participants were screened. A total of 60 individuals were then selected through simple random sampling and assigned, using the same method, into three groups of 20 participants each. Finally, two groups were randomly designated as experimental groups (Schema Therapy and Emotionally Focused Therapy [EFT]) and one group as the control group.

The inclusion criteria were as follows: being legally married couples; having at least one year of marital life; experiencing marital problems (such as low intimacy and poor empathy) as diagnosed by a counselor or through referral from counseling centers; being between 25 and 55 years of age for both spouses; possessing at least a high school diploma in order to comprehend the therapeutic session concepts; providing informed consent to participate in the study and attend therapy sessions; not simultaneously receiving similar interventions (e.g., schema therapy or EFT in parallel); and obtaining scores between 162 and 270 on the Marital Conflict Questionnaire. The exclusion criteria included: ongoing divorce proceedings or a definitive decision for separation; lack of cooperation or repeated absence from therapy sessions; and unwillingness to continue participation in the study at any stage.

It should be noted that, after obtaining an official introduction letter from the Islamic Azad University, Borujerd Branch, coordination was established with the directors of family counseling centers in Hamadan in order to gain access to the centers and obtain the necessary information regarding couples. In collaboration with the staff of the respective centers, a list of couples who had referred to the centers for counseling services during the first quarter of 2025 was prepared. Following the initial screening process, two groups were randomly assigned as experimental groups (Schema Therapy and Emotionally Focused Therapy [EFT]) and one group was selected as the control group. After group formation, explanations regarding the intervention process were first provided to the experimental groups, and participants were asked to attend all sessions actively. Subsequently, intervention sessions were conducted for the two experimental groups in the conference room section based on the treatment protocol of each group. The seating arrangement was organized in a semicircular format to facilitate group participation. Prior to the

implementation of the interventions, questionnaires were distributed among all three groups. Following the completion of the intervention sessions, the questionnaires were again administered to participants. Members of the control group were contacted and invited to attend the counseling centers in order to complete the questionnaires. Finally, two months after the posttest implementation, the questionnaires were once again completed for the follow-up phase.

Data Collection

Sanai's Marital Conflict Questionnaire (MCQ; 1996): This instrument was used for the initial screening process. Each item includes five response options scored from 1 to 5. The maximum total score of the questionnaire is 270 and the minimum score is 54. The maximum score for each subscale is equal to the number of items in that subscale multiplied by 5. In this instrument, higher scores indicate greater marital conflict, whereas lower scores indicate better relationships and less conflict. The scoring format is as follows: Never (1), Rarely (2), Sometimes (3), Often (4), and Always (5). Items 3, 11, 14, 26, 30, 33, 45, 47, and 54 are reverse scored. In the study conducted by Sanai (1996), the Cronbach's alpha coefficient of the questionnaire was reported as .88.

Mehrabian and Epstein Empathy Scale (1972): The empathy questionnaire consists of 33 items and was developed by Mehrabian and Epstein in 1972. The scale is used to assess individuals' levels of empathy and includes seven components: reactive empathy, expressive empathy, participatory empathy, emotional susceptibility, emotional stability, empathy toward others, and control.

Beck Depression Inventory-II (BDI-II; 1996): The Beck Depression Inventory was first developed by Beck and colleagues in 1961. The Beck Depression Inventory-II consists of 21 items designed to assess the responses and symptoms of depressed patients. The items were developed based on observations and summaries of common attitudes and symptoms among psychiatric patients with depression. In other words, the items and their weights were logically selected. The content of this questionnaire comprehensively reflects the symptomatology of depression, although it primarily emphasizes cognitive content. The BDI-II is a self-report instrument completed within approximately five to ten minutes. The test items include 21 symptoms-related items, which respondents answer on a four-point scale ranging from 0 to 3. These items assess domains such as sadness, pessimism, feelings of helplessness and failure, guilt feelings, sleep disturbance, loss of appetite, self-dislike, and similar symptoms. Specifically, two items relate to affect, 11 items to cognition, two items to overt behaviors, five items to somatic symptoms, and one item to interpersonal symptomatology. Therefore, this scale determines varying levels of depression ranging from mild to extremely severe, with scores ranging from 0 to 63.

Intervention

In the present study, group schema therapy for couples was conducted in 12 sessions of 90 minutes each based on the protocols developed by Jeffrey Young and colleagues (2003) and Young and Klosko (2003). During the first session, couples became acquainted with one another and with the therapist, while the objectives of group therapy, the concepts of schema, coping styles, and schema therapy, as well as group rules and confidentiality principles, were introduced. In the second session, the 18 early maladaptive schemas proposed by Young were introduced in a general manner, and the relationship between schemas

and unmet basic childhood needs was explained. Participants were then guided to identify their own active schemas and those of their spouses. The third session focused on the five major schema domains and the role of parents in schema formation, followed by a writing exercise in which participants described childhood memories associated with the roots of their current schemas. In the fourth session, coping responses including surrender, avoidance, and overcompensation were explained, along with common coping styles observed in marital relationships, and couples analyzed their own and their spouses' coping styles during conflicts. The fifth session addressed schema activation triggers within interpersonal communication and the relationship between schemas and misunderstandings, aggression, or emotional withdrawal, with participants identifying situations that activated their schemas. In the sixth session, the concept of the "Healthy Adult" mode was introduced, and its role in regulating schemas was discussed. Participants practiced responding to their spouses' schemas from the Healthy Adult perspective. During the seventh session, painful childhood memories were reconstructed through therapist-guided experiential exercises conducted individually within the group setting, aiming to modify emotional experiences associated with schemas. The eighth session focused on role-playing internal modes such as the punitive parent, vulnerable child, and healthy adult, utilizing the empty-chair dialogue technique, while couples practiced therapeutic dialogues shifting from maladaptive to adaptive modes. In the ninth session, unresolved relational conflicts and methods of rebuilding trust were explored, and couples reconstructed a real conflict using healthy and empathic communication strategies. The tenth session emphasized nonjudgmental listening, emotional reflection, and empathy techniques, and each couple practiced a real-life relational scenario through guided dialogue. In the eleventh session, realistic goals were established for each couple, homework assignments were designed to strengthen the Healthy Adult mode, and "if–then" plans were prepared for schema-triggering situations. Finally, the twelfth session involved reviewing the therapeutic process, evaluating cognitive, emotional, and behavioral changes, providing group feedback, and preparing a follow-up and evaluation plan for three months after treatment completion.

In the present study, group Emotionally Focused Therapy (EFT) for couples was conducted in 12 sessions of 90 minutes each based on the protocol developed by Sue Johnson and Leslie Greenberg (1980). In the first session, group members and therapists were introduced, the principles and objectives of Emotionally Focused Therapy were explained, and group rules including confidentiality, mutual respect, and nonjudgmental interaction were established. Couples were also asked to express their expectations regarding both their relationship and the therapeutic process. The second session focused on identifying negative interaction cycles, such as pursuer–withdrawer patterns, and educating participants about the effects of repetitive maladaptive behavioral patterns, followed by exercises aimed at recognizing their own interaction cycles. During the third session, couples learned to differentiate between primary emotions, such as fear, sadness, and the need for connection, and secondary emotions, such as anger and withdrawal, and they described situations in which secondary emotions had contributed to relational conflicts. The fourth session explored fundamental attachment needs including belongingness, safety, and acceptance, and participants practiced articulating and communicating their attachment needs within the relationship. In the fifth session, emphasis was placed on suppressed emotions such as fear of rejection and feelings of being ignored, and participants engaged in exercises involving the honest expression of vulnerable emotions to their spouses. The sixth session focused on active listening and empathic responding skills, during which couples

practiced communication using statements beginning with "I feel... because...". In the seventh session, secure attachment interactions were strengthened, and couples practiced providing supportive and validating feedback to one another. The eighth session aimed to increase emotional acceptance between partners, and participants practiced emotionally responsive behaviors toward their spouses' vulnerability. In the ninth session, couples developed new relational agreements and wrote emotional commitment statements for one another. The tenth session involved reviewing relational achievements and applying learned therapeutic skills in real-life situations. During the eleventh session, barriers associated with returning to negative interaction patterns were examined, and couples developed strategies for managing future conflicts. Finally, in the twelfth session, the therapeutic process was comprehensively reviewed, personal and relational changes were evaluated, and participants celebrated their progress while exchanging mutual feedback within the group setting.

Data Analysis

After data collection, and according to the measurement level of the data and statistical assumptions (normality, homogeneity of variances, homogeneity of covariance matrices, and the sphericity assumption), repeated measures analysis of variance and Bonferroni post hoc test were used to analyze the data at a significance level of .05 using SPSS software version 26. In the present study, all ethical considerations, including informed consent and confidentiality of participants' information, were fully observed.

Findings and Results

Based on the obtained findings, each group consisted of 20 participants, including 10 women and 10 men in all three groups. Regarding age distribution, in the schema therapy intervention group, 7 participants were between 25 and 35 years old, 8 participants were between 36 and 45 years old, and 5 participants were between 46 and 55 years old. In the Emotionally Focused Therapy (EFT) intervention group, 6 participants were between 25 and 35 years old, 9 participants were between 36 and 45 years old, and 5 participants were between 46 and 55 years old. Similarly, in the control group, 6 participants were between 25 and 35 years old, 8 participants were between 36 and 45 years old, and 6 participants were between 46 and 55 years old. Regarding educational level, in the schema therapy intervention group, 4 participants had a high school diploma or associate degree, 11 participants had a bachelor's degree, and 5 participants had a master's degree or higher. In the Emotionally Focused Therapy intervention group, 5 participants had a high school diploma or associate degree, 10 participants had a bachelor's degree, and 5 participants had a master's degree or higher. Finally, in the control group, 4 participants had a high school diploma or associate degree, 11 participants had a bachelor's degree, and 5 participants had a master's degree or higher.

Table 1. Means and Standard Deviations of Schema Therapy, Emotionally Focused Therapy, Empathy, and Depression

Variable	Group	Pretest Mean	Pretest SD	Posttest Mean	Posttest SD	Follow-up Mean	Follow-up SD
Empathy	Control	57.80	11.50	43.75	8.70	43.75	8.70
	Schema Therapy	57.80	13.44	104.80	10.31	103.35	8.81

	Emotionally Focused Therapy	60.70	13.35	140.75	12.85	135.35	9.65
Depression	Control	50.50	6.50	50.20	6.49	50.20	6.49
	Schema Therapy	48.85	11.94	15.30	5.31	13.45	6.80
	Emotionally Focused Therapy	49.30	10.76	11.50	5.43	10.30	6.57

Based on the results presented in Table 1, the mean depression scores in the control group at pretest, posttest, and follow-up were 50.50, 50.20, and 50.20, respectively. In the schema therapy experimental group, the mean depression scores were 48.85, 15.30, and 13.45, respectively, while in the Emotionally Focused Therapy experimental group, the corresponding means were 49.30, 11.50, and 10.30.

The results obtained from the assumption tests indicated that Box's M and Levene's tests were not significant for any of the research variables ($p > .05$). Therefore, the assumptions of homogeneity of covariance matrices and homogeneity of variances for the variables of empathy and depression across the three measurement stages were satisfied. The results of Mauchly's sphericity test indicated that the assumption of equality of within-subject variances across the three stages was not met for the dependent variables ($p < .05$). Accordingly, considering that the Greenhouse–Geisser epsilon value was less than .71, the Huynh–Feldt correction was applied.

Table 2. Results of Within-Group Comparisons for Depression and Empathy Scores

Source	Measure	SS	df	MS	F	Sig.	Test Power
Depression	Linear	18600.300	1	18600.300	366.844	.001	.855
	Quadratic	6952.011	1	6952.011	294.059	.001	.838
Depression × Group	Linear	9142.200	2	4571.100	82.781	.001	.744
	Quadratic	3435.756	2	1717.878	72.664	.001	.718
Error	Linear	3147.500	57	55.219			
	Quadratic	1347.567	57	23.642			
Empathy	Linear	37524.033	1	37524.033	391.358	.001	.873
	Quadratic	15946.711	1	15946.711	367.835	.001	.866
Empathy × Group	Linear	40878.717	2	20439.358	213.173	.001	.882
	Quadratic	16858.839	2	8429.419	194.437	.001	.872
Error	Linear	5465.250	57	95.882			
	Quadratic	2471.117	57	43.353			

Based on Table 2, the results demonstrated that there was a significant difference in depression scores across the different measurement stages (pretest, posttest, and follow-up), $F(1, 57) = 366.844$, $p < .001$. Furthermore, the findings indicated a significant difference among the research groups (schema therapy, Emotionally Focused Therapy, and control group) in depression scores, $F(1, 57) = 82.781$, $p < .001$. The trend of changes across the three stages followed a quadratic pattern, indicating that the scores at pretest, posttest, and follow-up significantly differed from one another. Therefore, Bonferroni post hoc analysis was conducted to examine the differences among the three stages, and the results are presented in Table 3.

Additionally, based on Table 2, the findings revealed a significant difference in empathy scores across the different measurement stages (pretest, posttest, and follow-up), $F(1, 57) = 391.358$, $p < .001$. The results further indicated a significant difference among the research groups (schema therapy, Emotionally Focused Therapy, and control group) in empathy scores, $F(1, 57) = 213.173$, $p < .001$. The trend of changes across the three stages also followed a quadratic pattern, indicating significant differences among pretest, posttest, and follow-up scores. Accordingly, Bonferroni post hoc analysis was used to examine these differences, and the results are presented in Table 3.

Table 3. Results of Pairwise Comparisons Across Measurement Stages for Depression and Empathy

Dependent Variable	Compared Stages	Mean Difference	Standard Error	Significance Level
Depression	Pretest–Posttest	25.633	1.429	.001
	Pretest–Follow-up	24.900	1.357	.001
	Follow-up–Posttest	-0.733	0.248	.013
Empathy	Pretest–Posttest	-37.650	1.889	.001
	Pretest–Follow-up	-35.367	1.788	.001
	Follow-up–Posttest	-2.283	0.445	.006

Based on the results presented in Table 3, there was a significant difference between pretest and posttest depression scores ($p < .001$), and the mean depression score at posttest was lower than at pretest. This finding indicates that the treatment sessions in both schema therapy and Emotionally Focused Therapy significantly reduced participants' depressive symptoms. The findings also demonstrated a significant difference between pretest and follow-up depression scores ($p < .001$), indicating that depression scores at follow-up remained lower than at pretest, suggesting that the treatment effects were stable over time. Furthermore, the results indicated no significant difference between posttest and follow-up depression scores.

Similarly, based on the results presented in Table 3, there was a significant difference between pretest and posttest empathy scores ($p < .001$), and the mean empathy score at posttest was higher than at pretest. This finding demonstrates that both schema therapy and Emotionally Focused Therapy significantly increased participants' empathy levels. Moreover, the findings revealed a significant difference between pretest and follow-up empathy scores ($p < .001$), indicating that empathy scores at follow-up remained higher than at pretest, which suggests that the therapeutic effects were maintained over time. In addition, no significant difference was observed between posttest and follow-up empathy scores.

Table 4. Results of Post Hoc Comparisons Between Groups

Dependent Variable	Compared Groups	Mean Difference	Standard Error	Significance Level
Depression	Schema Therapy–Emotionally Focused Therapy	-2.150	2.1260	.013
	Schema Therapy–Control	-25.3167	2.1260	.001
	Emotionally Focused Therapy–Control	-27.4667	2.1260	.001
Empathy	Schema Therapy–Control	23.600	1.54168	.001
	Emotionally Focused Therapy–Control	63.933	1.54168	.001
	Emotionally Focused Therapy–Schema Therapy	40.233	1.54168	.001

Based on the results presented in Table 4, there was a significant difference among the groups in depression scores ($p < .001$). The mean difference in depression scores between the schema therapy and Emotionally Focused Therapy experimental groups was -2.150 (SE = 2.1260), which was significant at the .01 level. Furthermore, the mean difference between the schema therapy group and the control group was -25.3167 (SE = 2.1260), which was also significant at the .01 level, while the mean difference between the Emotionally Focused Therapy group and the control group was -27.4667 (SE = 2.1260). These findings indicate that both schema therapy and Emotionally Focused Therapy significantly reduced depressive symptoms among participants. Additionally, the results showed that depression scores in the Emotionally Focused Therapy group were significantly lower than those in the schema therapy group ($p < .001$).

The findings also demonstrated a significant difference among the groups in empathy scores ($p < .001$). The mean difference in empathy scores between the experimental groups was 23.600 (SE = 1.54168), which

was significant at the .01 level. Moreover, the mean difference between the schema therapy group and the control group was 63.833 (SE = 1.54168), while the mean difference between the Emotionally Focused Therapy group and the control group was 40.233 (SE = 1.54168), both of which were significant at the .01 level. These findings indicate that both schema therapy and Emotionally Focused Therapy significantly increased empathy among participants. Furthermore, the results showed that empathy scores in the schema therapy group were significantly higher than those in the Emotionally Focused Therapy group ($p < .001$).

Discussion and Conclusion

The findings of the present study demonstrated that acceptance and commitment-based intervention training significantly improved marital satisfaction, marital communication, and sexual relationships among women with Obsessive–Compulsive Disorder (OCD) compared to the control group. Specifically, the results indicated that while the control group showed minimal changes from pretest to posttest across all three variables, the experimental group exhibited substantial increases in posttest scores, suggesting that the intervention had a meaningful and statistically significant effect. These results are consistent with the theoretical foundations of Acceptance and Commitment Therapy (ACT), which emphasize enhancing psychological flexibility, reducing experiential avoidance, and promoting value-driven behaviors. Given that OCD is characterized by rigid cognitive patterns and maladaptive avoidance strategies, the observed improvements can be interpreted as a direct outcome of increased acceptance of internal experiences and reduced fusion with obsessive thoughts, ultimately facilitating more adaptive interpersonal functioning.

The improvement in marital communication observed in this study can be explained through the mechanisms of mindfulness and cognitive defusion emphasized in ACT. By learning to observe thoughts and emotions without judgment and reducing their automatic influence on behavior, participants likely developed greater emotional awareness and responsiveness during interpersonal interactions. This aligns with prior research indicating that ACT-based interventions enhance interpersonal relationships and empathy in individuals with OCD (20). Furthermore, improved communication patterns have been reported in couples undergoing ACT-based interventions, where individuals learn to respond to relational challenges with openness and flexibility rather than avoidance or reactivity (21). The current findings support these conclusions, suggesting that ACT facilitates healthier communication by modifying the individual's relationship with internal experiences rather than attempting to eliminate them.

Similarly, the significant increase in marital satisfaction among participants in the experimental group can be attributed to the value-based component of ACT. By identifying and committing to personal and relational values, individuals are encouraged to engage in behaviors that enhance relationship quality despite the presence of distressing thoughts or emotions. This process likely contributed to a greater sense of fulfillment and satisfaction within the marital relationship. Previous studies have consistently demonstrated that ACT interventions improve marital satisfaction and relational quality across various populations (22, 23). In particular, ACT-based couple therapy has been shown to enhance emotional regulation and marital quality of life in distressed couples, further supporting the role of psychological flexibility in promoting relational well-being (24). The present findings extend this evidence to women with OCD, highlighting the applicability of ACT in populations with complex psychological conditions.

The observed improThe present study was conducted with the aim of comparing the effectiveness of schema therapy and Emotionally Focused Therapy (EFT) on increasing empathy and reducing symptoms of marital depression among couples. The findings demonstrated that both schema therapy and Emotionally Focused Therapy significantly improved empathy and reduced depressive symptoms in comparison with the control group. Furthermore, the results indicated that schema therapy was more effective in increasing empathy, whereas Emotionally Focused Therapy was more effective in reducing depressive symptoms. The stability of the results during the follow-up phase also suggested that the therapeutic effects of both interventions were relatively enduring over time.

One of the major findings of the present study was that schema therapy significantly increased empathy among couples. This finding is theoretically consistent with schema theory, which proposes that maladaptive schemas distort interpersonal perception, emotional responsiveness, and relational interpretation. Individuals with early maladaptive schemas often interpret marital interactions through the lens of abandonment, mistrust, emotional deprivation, defectiveness, or rejection, leading to defensive reactions and reduced empathic understanding toward their spouses. Schema therapy helps individuals identify these maladaptive schemas, recognize the origins of their emotional reactions, and gradually replace maladaptive coping responses with healthier and more adaptive interpersonal behaviors. Through techniques such as cognitive restructuring, experiential imagery, role-playing, and healthy adult mode activation, individuals become more capable of differentiating past emotional injuries from present relational realities. As a result, emotional understanding and empathic responsiveness toward the spouse improve.

The findings related to empathy are aligned with previous studies indicating that schema-focused interventions can positively affect empathy and emotional functioning. Mohammadian et al. reported that schema therapy significantly improved empathy among married women referring to counseling centers (9). Similarly, Mohammd et al. demonstrated that schema therapy reduced cognitive avoidance and anxiety while improving empathy among couples with marital difficulties (10). In addition, Mohammadi Aminzadeh et al. found that emotional schemas were predictive of perceived empathy, suggesting that schema-related emotional structures directly influence empathic functioning (13). These findings collectively support the notion that maladaptive schemas interfere with emotional understanding and that schema modification may strengthen empathic processes in intimate relationships.

Another explanation for the positive effect of schema therapy on empathy may involve the activation of the healthy adult mode during therapeutic sessions. In schema therapy, couples learn to regulate emotional reactions from a balanced and reflective position rather than from vulnerable child or punitive parent modes. This process enables spouses to tolerate emotional discomfort, understand the emotional experiences of one another, and respond in a more compassionate and emotionally attuned manner. Such therapeutic changes may explain why the schema therapy group demonstrated significantly higher empathy scores than the Emotionally Focused Therapy group at posttest and follow-up. Because schema therapy directly addresses deep cognitive-emotional structures and long-standing relational patterns, it may produce stronger changes in the cognitive and affective dimensions of empathy over time.

The present study also demonstrated that Emotionally Focused Therapy significantly increased empathy among couples. This finding is consistent with the theoretical assumptions of attachment theory and the EFT model, which emphasize emotional accessibility, responsiveness, and engagement within intimate

relationships. EFT conceptualizes marital conflict as the product of insecure emotional bonding and maladaptive interaction cycles rather than merely communication deficits. Through the identification and expression of primary emotions and attachment needs, couples gradually develop emotional safety and responsiveness toward one another. This process naturally facilitates empathy because partners become more capable of understanding each other's vulnerability, emotional pain, and relational needs.

The findings concerning the effectiveness of EFT on empathy are consistent with previous research. Jahari reported that Emotionally Focused Therapy improved marital satisfaction and emotional empathy among couples referring to counseling centers (4). Similarly, Shapourifar demonstrated that relationship enrichment training based on an emotion-focused approach significantly improved marital empathy and emotional regulation among couples (5). Khushbakht et al. also found that emotion-focused couple therapy improved cognitive-affective empathy among couples experiencing marital conflict (3). These studies support the interpretation that EFT strengthens empathy by facilitating emotional disclosure, reducing defensive interactions, and increasing emotional responsiveness within the marital relationship.

Despite the effectiveness of both interventions in improving empathy, schema therapy demonstrated stronger effects than EFT in the present study. One possible explanation is that schema therapy directly targets maladaptive cognitive and emotional structures that interfere with empathic processing. Individuals with rigid schemas often misinterpret neutral or ambiguous marital behaviors as threatening or rejecting, which reduces their capacity for empathic perspective-taking. By restructuring these schemas, schema therapy may create more enduring changes in how spouses perceive and emotionally process relational experiences. In contrast, EFT focuses more heavily on emotional interaction patterns and attachment responsiveness, which may improve emotional closeness but may not modify deep schema-driven interpretations to the same extent.

Another important finding of the present study was that both schema therapy and EFT significantly reduced symptoms of marital depression. Depression in couples is often associated with emotional disconnection, negative cognitive patterns, hopelessness, low emotional support, and recurrent relational conflict. Both interventions appear to reduce depressive symptoms by improving emotional functioning and interpersonal responsiveness, although they may do so through different therapeutic pathways.

The reduction of depressive symptoms in the schema therapy group can be explained through schema modification and emotional restructuring. Depression is frequently associated with maladaptive schemas related to failure, defectiveness, emotional deprivation, dependence, and pessimism. Schema therapy attempts to challenge and transform these dysfunctional cognitive-emotional patterns while helping individuals develop healthier self-perceptions and coping responses. Previous studies have shown that maladaptive schemas are strongly associated with depression and existential anxiety (6, 7). Research has also demonstrated that schema-focused interventions can reduce depression-related symptoms and improve psychological functioning. Kopf-Beck et al. reported that schema therapy was effective for depression in inpatient and day clinic settings (8). Similarly, Kool et al. found that schema therapy produced significant therapeutic effects in individuals with comorbid depression and personality disorders (12). These findings are consistent with the present study and support the role of schema modification in reducing depressive symptoms.

The reduction of depressive symptoms in the EFT group may be explained by the intervention's focus on emotional processing, attachment security, and relational responsiveness. Depression often involves emotional withdrawal, loneliness, hopelessness, and difficulty expressing vulnerability. EFT creates a therapeutic environment in which couples can safely access and communicate primary emotions such as fear, sadness, shame, and unmet attachment needs. As partners respond more supportively and empathically to one another, emotional isolation decreases and relational security increases. These changes may directly reduce depressive symptoms by improving emotional connectedness and perceived support.

The findings of the present study regarding the effectiveness of EFT on depression are supported by previous studies. Doshmanfana et al. reported that emotion-focused therapy significantly improved emotion regulation and resilience among patients with chronic pain and depressive symptoms (14). Kiakojori and Khajevand Khoshli also demonstrated that EFT reduced psychological and emotional symptoms among depressed women (15). Furthermore, Hatami Nejad et al. found that Emotionally Focused Therapy reduced depression and maladaptive schemas among students with suicidal thoughts (16). Far et al. similarly concluded that both schema therapy and EFT improved optimism and meaning in life among individuals with major depressive disorder (17). These findings collectively indicate that emotional processing and attachment-based interventions may effectively reduce depressive symptoms across different populations.

An important result of the present study was that EFT demonstrated stronger effects than schema therapy in reducing depressive symptoms. This finding may be explained by the central role of emotional disconnection and attachment insecurity in marital depression. While schema therapy primarily focuses on cognitive-emotional structures and long-term maladaptive patterns, EFT directly addresses present emotional experiences and relational distress within the couple interaction cycle. Because depressive symptoms in couples are often intensified by emotional isolation, lack of validation, and insecure attachment dynamics, EFT may produce more immediate emotional relief through emotional engagement and corrective attachment experiences. In other words, when couples begin to experience emotional safety, validation, and responsiveness from one another, depressive symptoms may decrease more rapidly.

The maintenance of treatment effects during follow-up is another important aspect of the findings. The persistence of improvements in empathy and depression suggests that both schema therapy and EFT generated relatively stable cognitive, emotional, and relational changes. In schema therapy, this stability may result from the restructuring of deep maladaptive schemas and the strengthening of healthy coping modes. Once individuals become aware of their schemas and learn healthier emotional responses, these patterns may continue beyond the therapy sessions. In EFT, the stability of outcomes may stem from the restructuring of emotional interaction cycles and the development of more secure attachment bonds between partners. Once couples learn to respond to one another in emotionally supportive ways, these new interaction patterns may become self-reinforcing over time.

The present findings are also consistent with broader theoretical models emphasizing the interaction between cognition, emotion, and interpersonal functioning. Jalalvand et al. showed that emotional divorce is associated with maladaptive schemas and emotion regulation difficulties (1). Rahmanian and Arefinia also highlighted the role of resilience and maladaptive schemas in marital forgiveness among betrayed women with depression (2). These studies suggest that emotional and cognitive vulnerabilities significantly influence relational functioning and psychological well-being. The present study extends these findings by

demonstrating that therapeutic interventions targeting schemas and emotional attachment processes can improve empathy and reduce depressive symptoms among couples.

Another important implication of the present findings concerns the integration of cognitive and emotional approaches in couple therapy. Although schema therapy and EFT are theoretically distinct, both interventions address emotional needs, maladaptive relational patterns, and interpersonal responsiveness. Schema therapy emphasizes cognitive-emotional restructuring and developmental origins of distress, whereas EFT emphasizes attachment security and emotional engagement. The effectiveness of both interventions suggests that marital distress and depressive symptoms are multidimensional phenomena requiring attention to both cognitive structures and emotional interaction patterns. Therefore, integrative therapeutic approaches that combine schema-focused and emotion-focused techniques may potentially produce even greater clinical benefits for couples experiencing chronic relational distress and depression.

The findings of this study also have implications for counseling centers and clinical practice. Couples experiencing marital conflict often seek treatment after years of unresolved emotional injuries, repetitive conflicts, and emotional disconnection. Interventions such as schema therapy and EFT may provide therapists with effective frameworks for addressing both individual vulnerabilities and interpersonal interaction patterns. Because empathy and emotional responsiveness are essential components of marital adjustment, therapeutic approaches that improve these variables may contribute to long-term relational stability and psychological well-being.

One limitation of the present study was the relatively small sample size and the restriction of participants to couples referring to counseling centers in the city of Hamadan, which may limit the generalizability of the findings to other populations and cultural contexts. Another limitation was the reliance on self-report questionnaires, which may be influenced by response bias and social desirability. Additionally, the follow-up period was relatively short, and therefore the long-term durability of the treatment effects could not be fully evaluated. The absence of qualitative assessments and observational measures of couple interaction was another limitation that may have restricted deeper understanding of relational changes during treatment.

Future research is recommended to examine the long-term effects of schema therapy and Emotionally Focused Therapy using larger and more culturally diverse samples. Researchers may also compare these interventions across different types of marital problems, levels of depression severity, and stages of marital life. The inclusion of qualitative methods, observational assessments, and mixed-methods designs could provide more comprehensive insight into the mechanisms underlying therapeutic change. Furthermore, future studies may investigate integrative therapeutic protocols combining schema-focused and emotion-focused approaches in order to determine whether combined interventions produce stronger or more sustainable outcomes.

From a practical perspective, counseling centers and mental health professionals may benefit from incorporating schema therapy and Emotionally Focused Therapy into couple counseling programs for couples experiencing empathy deficits, emotional disconnection, and depressive symptoms. Training therapists in both schema-focused and emotion-focused techniques may improve treatment flexibility and enhance intervention effectiveness in marital counseling settings. Preventive workshops focusing on

emotional awareness, empathic communication, schema recognition, and attachment security may also help couples strengthen relational resilience before severe marital distress develops.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

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

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