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Original Article

A Comparison of the Effectiveness of Mindfulness-Integrated Mode-Based Schema Therapy and Mentalization-Based Treatment on Self-Esteem in Women with Traumatic Experiences

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Abstract

Background and Objective: Women with a history of trauma often experience reduced self-esteem, maladaptive self-schemas, and difficulties in emotion regulation and interpersonal functioning. Although both mindfulness-integrated mode-based schema therapy (MBST) and mentalization-based treatment (MBT) have demonstrated effectiveness in improving psychological functioning and self-concept, direct comparative evidence on their impact on self-esteem in traumatized women remains limited. This study aimed to compare the effectiveness of MBST and MBT in enhancing self-esteem among women with trauma histories.

Materials and Methods: This randomized controlled clinical trial used a pretest–posttest design with a three-month follow-up and included two intervention groups and one control group. The study population comprised women with documented histories of trauma who were referred to psychological and counseling clinics in Ahvaz, Iran, between 2025 and 2026. Forty-eight participants were selected via purposive sampling and randomly assigned to an MBST group (n = 16), an MBT group (n = 16), or a control group (n = 16). Self-esteem was assessed with the Coopersmith Self-Esteem Inventory. Data were analyzed in SPSS (version 27) using repeated-measures analysis of covariance and Kruskal–Wallis H tests, with significance set at 0.05.

Results: Both interventions significantly increased participants' self-esteem scores compared with the control group ($P < 0.001$). Among the two treatment groups, the MBT group had a significantly higher mean self-esteem than the MIST group ($P < 0.001$). Finally, both methods were more effective than the control, with mentalization-based therapy more effective than schema therapy in increasing self-esteem.

Conclusion: Both MBST and MBT were effective in improving self-esteem among women with trauma experiences. However, MBT demonstrated a stronger and more sustained effect at follow-up. These findings suggest that MBT may offer superior long-term benefits for enhancing self-esteem in traumatized women, although MBST also yields meaningful and durable improvements.

Keywords: Mode-based schema therapy, Mentalization-based treatment, Self-esteem, Trauma, Women

Background

Trauma, particularly when experienced during childhood or adolescence, can exert profound and long-lasting effects on mental health and overall quality of life. Among women, traumatic experiences are frequently associated with post-traumatic stress disorder, anxiety, depression, and impairments in psychosocial functioning [1]. Trauma exposure is one of the most destabilizing influences on the psychological foundations of the self. Due to greater sensitivity to psychosocial stressors, women often experience more severe and persistent psychological sequelae following traumatic events. Interpersonal forms of trauma, such as domestic violence, are especially likely to result in deep emotional, relational, and self-evaluative disturbances. Evidence further indicates that early adversities, including abuse and neglect, significantly impair interpersonal and familial functioning in adulthood [2].

Women exposed to trauma commonly exhibit heightened psychological vulnerability and maladaptive defensive patterns [3]. Importantly, the impact of trauma extends beyond symptom-based manifestations of anxiety and depression and

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frequently compromises core components of self-concept, particularly perceived self-worth and self-esteem [4]. Self-esteem, defined as an individual's global evaluation of personal worth, plays a central role in emotion regulation, interpersonal effectiveness, and adaptive coping. Consequently, disruptions in self-esteem may substantially hinder psychological recovery following traumatic experiences. Empirical research consistently demonstrates that individuals exposed to childhood trauma report lower levels of self-esteem in adulthood and face an increased risk of chronic affective disorders [5, 6].

Trauma-related disorders, including post-traumatic stress disorder, are characterized by persistent hyperarousal, avoidance behaviors, and heightened fear responses to trauma-related cues. These features can severely disrupt social relationships and everyday functioning in affected women [7]. Vulnerable populations, particularly traumatized women, often experience cumulative stressors, such as financial strain, occupational difficulties, and limited social support, which further exacerbate emotional distress [8]. Moreover, barriers to accessing mental health care, including stigma and mistrust of professionals, frequently prevent affected individuals from receiving adequate treatment. Trauma exposure may also increase stress sensitivity, such that relatively minor stressors provoke disproportionate anxiety responses [8]. For women in the Iranian context, these challenges are frequently compounded by specific cultural stressors, including social stigma, mistrust of mental health services, and limited access to specialized care [8, 9].

Given the pervasive and long-term consequences of trauma on mental health, identifying effective therapeutic interventions is of critical importance. A substantial proportion of mental health service users report early adverse experiences, and extensive research has highlighted the strong association between trauma exposure and current psychopathology, underscoring its influence on treatment responsiveness and long-term functioning. Traumatized women appear particularly vulnerable to shame, guilt, anxiety, and diminished self-esteem—factors that substantially undermine quality of life and coping capacity [5, 9].

Within this context, mindfulness-integrated mode-based schema therapy (MBST) represents a depth-oriented, integrative therapeutic approach that targets early maladaptive schemas and dysfunctional modes rooted in traumatic experiences. By incorporating mindfulness-based techniques, MBST promotes emotional awareness, self-compassion, and reconstruction of a damaged self-structure, thereby facilitating improvements in self-esteem [10–12]. Empirical evidence supports the effectiveness of this approach in reducing negative affect, enhancing self-esteem, and improving emotion regulation among trauma-exposed populations [13–17].

In contrast, mentalization-based treatment (MBT), grounded in attachment theory, focuses on strengthening individuals' capacity to understand and interpret their own and others' mental states. Enhanced mentalization is associated with improved emotion regulation, more stable interpersonal functioning, and the development of a coherent and resilient sense of self [18, 19]. Deficits in mentalization—commonly observed among traumatized women—are linked to fragile self-esteem and heightened emotional reactivity. Conversely, strengthening mentalizing capacity has been shown to reduce maladaptive emotional patterns and promote greater psychological integration [20, 21]. MBST targets early maladaptive schemas and dysfunctional modes via mindfulness and self-compassion [22, 26]. By fostering emotional awareness and reconstructing damaged self-structures, MBST facilitates the improvement of self-esteem [10, 11, 12, 17]. In contrast, MBT focuses on strengthening the capacity to interpret mental states [18, 19, 21]. By enhancing mentalizing capacity, MBT improves emotional regulation and fosters a coherent sense of self [18, 20]. While both MBST and MBT demonstrate efficacy in addressing trauma-related psychological distress [12, 16, 27], their therapeutic pathways differ significantly. MBST targets the content of early maladaptive schemas, whereas MBT enhances the process of mentalization. To the best of our knowledge, direct comparative evidence on how these mechanisms influence self-esteem in traumatized women, particularly within the Iranian cultural context, remains limited.

Objectives

Despite the demonstrated effectiveness of both approaches, few studies have directly compared their impact on self-esteem among women with trauma histories. This gap is notable, given that MBST and MBT target self-esteem through distinct therapeutic mechanisms. MBST primarily focuses on modifying maladaptive schemas and self-critical modes, whereas MBT emphasizes repairing relational experiences and enhancing reflective self-understanding. A direct comparison of these interventions may clarify which therapeutic processes are more effective in restoring self-esteem and may inform evidence-based clinical decision-making. Accordingly, this study aimed to

compare the effectiveness of MBST and MBT in enhancing self-esteem among women with trauma experiences.

Materials and Methods

Study Design

The present study was an applied research project conducted as a randomized clinical trial using a pretest–posttest–follow-up design with a three-month follow-up period. The study included two experimental groups and one control group. The experimental groups received mindfulness-integrated schema therapy and MBT, while the control group received no intervention during the study period. At the pretest stage, self-esteem questionnaires were administered to participants in all three groups. Subsequently, the therapeutic interventions were implemented for the experimental groups.

Participants and Sampling

The statistical population comprised all women with a history of trauma who were referred to psychological and counseling clinics in Ahvaz, Iran, between 2025 and 2026. The study sample consisted of 48 women with documented clinical records of trauma exposure. In this study, women with trauma experiences were defined as individuals who had experienced at least one traumatic event—an event involving an actual or perceived threat to the life, physical health, or psychological integrity of the woman herself or one of her close relatives. The relevant clinical documentation consisted of the file and clinical notes available at the counseling or psychology center, in which the traumatic event and its related psychological consequences were recorded by the center's therapist or psychologist. This documentation included the clinical history, the diagnostic interview report, and records of any prior referral related to post-traumatic difficulties.

Participants were selected using purposive sampling. After completion of the pretest, the participants were randomly assigned to the three groups—mindfulness-integrated schema therapy, MBT, and control—using a random number table. For this purpose, an independent researcher generated the random sequence based on the random number table, and the participants were assigned in order of enrollment to one of the three groups according to this sequence. Two experimental groups (n = 16 each) and one control group (n = 16). Sample size adequacy was determined using G*Power software [22]. Based on an a priori power analysis for repeated measures, assuming a medium-to-large effect size (f = 0.40), an alpha level of $\alpha = 0.05$, a statistical power of0.80, three groups, three measurement points (pretest, posttest, and follow-up), and a correlation of 0.50 among repeated measures, the minimum required sample size was calculated to be 45. To ensure equal allocation across groups, a total sample size of 48 participants (16 per group) was selected.

Inclusion and Exclusion Criteria

The inclusion criteria were as follows: being at least 20 years old; having a history of at least one traumatic event confirmed by both the clinical record and the screening interview; having sufficient physical and psychological health to participate in the sessions; being referred to psychological and counseling centers in Ahvaz; providing written informed consent; and not having participated in similar educational or therapeutic programs during the previous three months.

The exclusion criteria included the presence of any condition interfering with regular attendance at intervention sessions, absence from more than two in-person sessions, and failure to respond to more than eight items on the research questionnaires, which resulted in withdrawal from the study.

Procedure

The sampling and study implementation processes were conducted in several stages. After obtaining formal approval from the affiliated university, the researchers visited psychological counseling and psychotherapy centers in Ahvaz using a convenience approach. In accordance with research ethics and to avoid commercial promotion, the names of these centers are not disclosed.

Following coordination with the centers, potential participants were purposively selected. Initial screening interviews were conducted in person at the counseling centers. During these interviews, a clinical assessment was performed, and the objectives of the study and relevant ethical considerations were explained to the participants. Participants were given the opportunity to ask questions, which were addressed comprehensively by the researchers. Individuals who did not meet the inclusion criteria were excluded.

Eligible participants then completed the research instruments as part of the pretest assessment. Subsequently, participants were randomly allocated to the experimental and control groups, and the experimental groups were prepared to receive the respective interventions.

Interventions

The Mindfulness-Integrated Schema Therapy intervention consisted of nine 90-minute sessions delivered twice weekly and was conducted at one of

the counseling centers for the first experimental group [23]. The MBT intervention for the second experimental group comprised seven 90-minute sessions, also delivered twice weekly at one of the counseling centers [21]. The control group did not receive any intervention during the study period. Tables 1 and 2 summarize the intervention sessions. In addition, Figure 1 shows the CONSORT flow diagram illustrating the study process. During the study, a number of participants withdrew. Ultimately, data from 44 participants were analyzed. Overall, 13 participants were included in the mindfulness-based schema therapy group, 15 participants in the mentalization-based therapy group, and 16 participants in the control group. The reasons for participant exclusion from the study included non-attendance at sessions or excessive absence, failure to complete the questionnaires at the posttest or follow-up stages, voluntary withdrawal from continued participation in the study, and incomplete or invalid completion of the questionnaires.

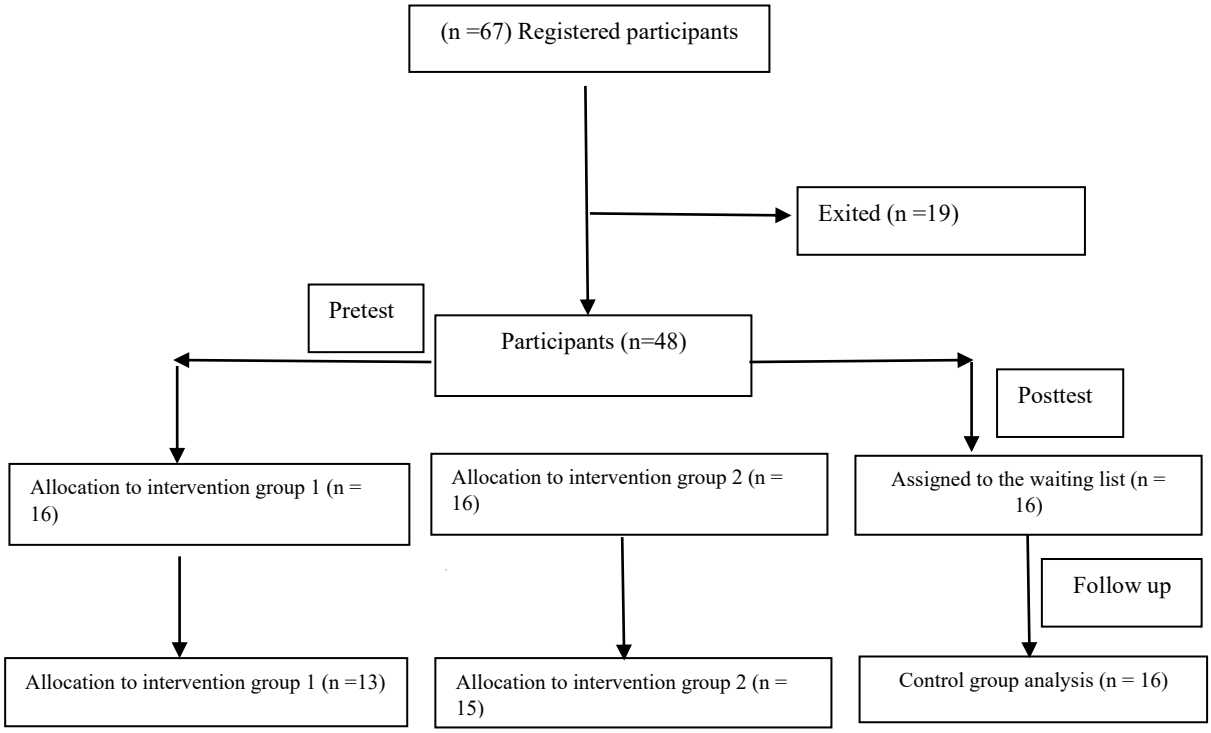


Figure 1: CONSORT Flowchart of the Study

Measures

Coopersmith Self-Esteem Inventory (SEI): The Coopersmith Self-Esteem Inventory (SEI) is a self-report questionnaire developed by Coopersmith in 1965 to assess individuals' levels of self-esteem [24]. The instrument consists of 58 items, eight of which function as lie-scale items. Responses were provided in a dichotomous yes/no format. The SEI assesses four dimensions of self-esteem: general self-esteem, social self-esteem, family self-esteem, and academic self-esteem. Total scores represent overall self-esteem, with higher scores indicating higher levels of self-esteem. The possible score ranged from 0 to 50. Scores of 26 or below indicate low self-esteem, scores between 27 and 43 indicate moderate self-esteem, and scores of 44 and above indicate high self-esteem. Cooper Smith reported test–retest reliability coefficients of 0.88 over a five-week interval in a sample of 50 children and 0.70 over a three-year interval in a sample of 56 twelve-year-old children. In Iranian samples, the Cronbach's alpha coefficient has been reported as 0.88 [25]. In the present study, the Cronbach's alpha coefficient for the SEI was also 0.88.

Table 1. Protocol of Mindfulness-Integrated Schema Therapy Sessions

Session	Goal	Core Content
1	Alliance and orientation	Introduction to MI-ST, rules, safety, pretest
2	Schema awareness	Core schemas, coping styles, safe bubble
3	Coping modes	Identifying maladaptive coping modes
4	Parent modes	Demanding/punitive parents, mode distancing

5	Vulnerable child	Emotional needs and self-compassion
6	Anger & impulsivity	Managing angry and impulsive child modes
7	Happy child	Activating positive child experiences
8	Healthy adult	Building and strengthening healthy adult mode
9	Consolidation	Skill review, relapse prevention, posttest

Table 2. Protocol of Mentalization-Based Treatment (MBT) Sessions

Session	Goal	Core Focus
1	Orientation	Introduction to mentalization and emotional awareness
2	Emotional differentiation	Primary vs. secondary emotions
3	Emotion regulation	Self-regulation and distress management
4	Skill development	Practice of mentalization skills
5	Clinical application	Mentalization in anxiety, self-esteem, shame, and guilt
6	Generalization	Applying mentalization to real-life situations
7	Integration	Mentalizing relationships and termination

Statistical Analyses

In this study, descriptive measures, such as mean and standard deviation, were used for descriptive statistics, and repeated measures analysis of covariance was used for inferential statistics. Also, the Kruskal-Wallis H method was used to examine the homogeneity of demographic variables. Similarly, the Tukey post hoc test was used to examine paired comparisons. Skewness and kurtosis tests were used to assess normal distribution, and Levene's test was used to assess the homogeneity of variances. All statistical analyses were conducted in SPSS (version 27) software, and a significance level of 0.05 was used.

Results

Participant data were collected at three measurement points: pretest, posttest, and follow-up. Analyses of demographic characteristics indicated adequate baseline comparability across the three groups. Most participants were between 20 and 30 years of age, and no significant age differences were observed among the Mindfulness-Integrated Schema Therapy (MIST), MBT, and control groups H = 0.021, P = 0.990. A bachelor's degree was the most common educational level across all groups, with no statistically significant between-group difference in education H = 2.192, P = 0.334. Most participants were married, and marital status did not differ significantly across groups H = 1.239, P = 0.538. Employment status was also similarly distributed, with no significant between-group difference H = 0.214, P = 0.899. Taken together, these findings suggest that the three groups were demographically comparable at baseline.

Table 3. Description Statistics

Variable	TIME	Groups	N	Mean	SD	Skewness	Kurtosis	Min	Max
Self-esteem	Pretest	Mindfulness-based schema therapy	13	26.8	2.154	0.116	-1.422	24.0	30.0
		Mentalization-based therapy	15	27.0	2.535	0.425	-0.850	24.0	32.0
		Control	16	26.4	1.965	0.257	-1.324	24.0	30.0
	Posttest	Mindfulness-based schema therapy	13	31.8	1.092	-0.373	-1.034	30.0	33.0
		Mentalization-based therapy	15	33.4	1.765	-0.439	-0.884	30.0	36.0
		Control	16	25.4	1.628	1.209	0.398	24.0	29.0
	Follow-up	Mindfulness-based schema therapy	13	32.7	0.630	0.307	-0.317	32.0	34.0
		Mentalization-based therapy	15	35.7	1.033	0.616	0.319	34.0	38.0
		Control	16	25.1	1.289	1.149	0.341	24.0	28.0

As shown in Table 3, pretest mean self-esteem scores were similar across the three groups (MIST: Mean = 26.8, SD = 2.154; MBT: Mean = 27.0, SD = 2.535; Control: Mean = 26.4, SD = 1.965), indicating minimal baseline differences. Skewness and kurtosis values were within acceptable ranges, supporting the assumption of approximate normality. At posttest, mean self-esteem scores were higher in both intervention groups (MIST: Mean = 31.8, SD = 1.092; MBT: Mean = 33.4, SD = 1.765) than in the control group (mean = 25.4, SD = 1.628). A similar pattern was observed at follow-up, with mean scores remaining higher in the MIST (mean = 32.7, SD = 0.630) and MBT (mean = 35.7, SD = 1.033) groups than in the control group (mean = 25.1, SD = 1.289). Descriptively, both intervention groups showed higher self-esteem scores over time relative to the control group, with the MBT group showing the highest mean scores at follow-up.

Table 4. Homogeneity of Variances Test

Variable	TIME	Statistics			
		F	Df 1	Df 2	*P*

Self-esteem	Posttest	3.09	2	41	0.056
	Follow up	1.74	2	41	0.188

According to Table 4, Levene's test indicated no statistically significant violation of the homogeneity of variances assumption at either posttest F(2,41) = 3.09, P = 0.056 or follow-up F(2,41) = 1.74, P = 0.188. These findings support the appropriateness of conducting the subsequent covariance analyses.

Table 5. Covariance Analysis Test

Variable		Source	Sum of Squares	Mean Square	F	*P* value	η^2_p
Self-esteem	Within-Subjects Effects	TIME	1.340	1.340	0.822	0.370	0.020
		TIME ✻ Pretest	0.626	0.626	0.384	0.539	0.010
		TIME ✻ group	27.684	13.842	8.489	< .001	0.298
		Residuals	65.221	1.631			
	Between Subjects Effects	Pretest	3.47	3.47	1.92	0.174	0.048
		group	26.14	13.07	7.24	0.002	0.276
		Pretest ✻ group	5.93	2.97	1.64	0.207	0.080

As presented in Table 5, after controlling for pretest self-esteem scores, the main effect of time was not statistically significant F = 0.822, P = 0.370, η^2_p = 0.020 and the interaction between time and pretest self-esteem was also non-significant F = 0.384, P = 0.539, η^2_p = 0.010. In contrast, the time × group interaction was statistically significant F = 8.489, P < 0.001, η^2_p = 0.298, indicating that the pattern of change across posttest and follow-up differed by group. The between-subjects main effect of group was also significant F = 7.24, P = 0.002, η^2_p = 0.276, suggesting a meaningful group effect within the model. However, the between-subjects effect of pretest self-esteem F = 1.92, P = 0.174, η^2_p = 0.048 and the pretest × group interaction F = 1.64, P = 0.207, η^2_p = 0.080 were not statistically significant.

Table 6. Post Hoc Comparisons - TIME ✻ Group for Self-esteem

TIME	Group	TIME	group	Mean Difference	SE	*df*	*t*	p_{tukey}
Post-test	Mindfulness-based schema therapy	Posttest	Mentalization-based therapy	-1.614	0.585	40.0	-2.759	0.086
		Posttest	Control	6.350	0.578	40.0	10.986	< .001
		Follow up	Mindfulness-based schema therapy	-0.931	0.501	40.0	-1.858	0.442
		Follow up	Mentalization-based therapy	-3.967	0.508	40.0	-7.813	< .001
		Follow up	Control	6.687	0.503	40.0	13.284	< .001
	Mentalization-based therapy	Posttest	Control	7.964	0.558	40.0	14.271	< .001
		Follow up	Mindfulness-based schema therapy	0.684	0.495	40.0	1.381	0.738
		Follow up	Mentalization-based therapy	-2.353	0.467	40.0	-5.035	< .001
		Follow up	Control	8.301	0.479	40.0	17.322	< .001
	Control	Follow up	Mindfulness-based schema therapy	-7.281	0.485	40.0	-14.999	< .001
		Follow up	Mentalization-based therapy	-10.317	0.474	40.0	-21.771	< .001
		Follow up	Control	0.337	0.453	40.0	0.744	0.975
Follow up	Mindfulness-based schema therapy	Follow up	Mentalization-based therapy	-3.037	0.400	40.0	-7.597	< .001
		Follow up	Control	7.618	0.395	40.0	19.293	< .001
	Mentalization-based therapy	Follow up	Control	10.654	0.381	40.0	27.949	< .001

Post Hoc Comparisons - Group

Group۱	Group۲	Mean Difference	SE	*t*	*P*
Mindfulness-based schema therapy	Mentalization-based therapy	-2.325	0.366	-6.355	< .001

	Control	6.984	0.361	19.320	< .001
Mentalization-based therapy	Control	9.309	0.349	26.674	< .001

Post hoc comparisons for the time × group interaction are presented in Table 6. At posttest, the difference in self-esteem scores between the MIST and MBT groups was not statistically significant; mean difference = −1.614, P = 0.086 Although both intervention groups scored significantly higher than the control group, P < 0.001. At follow-up, the MBT group showed significantly higher self-esteem scores than the MIST group mean difference = −3.037, P < 0.001. In addition, both intervention groups continued to score significantly higher than the control group at follow-up, P < 0.001. Within the repeated-measures comparisons, the increase from posttest to follow-up was not statistically significant in the MIST group mean difference = −0.931, P = 0.442 Whereas the corresponding increase in the MBT group was statistically significant mean difference = −2.353, P < 0.001. The control group showed no significant change between posttest and follow-up mean difference = 0.337, P = 0.975.

Taken together, these findings suggest that both intervention conditions were associated with higher self-esteem scores than the control condition at posttest and follow-up. However, the comparative advantage of MBT over MIST was not evident at posttest and became statistically significant only at follow-up. Accordingly, although the observed pattern may indicate stronger maintenance of gains in the MBT group, this interpretation should be made cautiously and in accordance with the statistical evidence presented.

Discussion

This study compared the effectiveness of MBST and MBT in improving self-esteem among women with a history of trauma and examined the maintenance of treatment effects over time. The findings indicate that both interventions were associated with significant improvements in self-esteem compared with the control group at posttest, and both remained superior to the control condition at follow-up. Although no statistically significant difference was observed between MBST and MBT at posttest, the MBT group showed significantly higher self-esteem scores at follow-up. Accordingly, both interventions appear beneficial in the short term, whereas the follow-up pattern may suggest stronger maintenance of gains in the MBT group.

The absence of a significant posttest difference between MBST and MBT may be understood in light of conceptual overlap between the two interventions in addressing trauma-related disturbances in self-organization. Trauma exposure is often associated with disruptions in self-worth, affect regulation, and interpersonal functioning [5, 6, 9]. Within MBST, therapeutic work focuses on modifying maladaptive modes and schema-driven self-evaluations, particularly those involving defectiveness, shame, guilt, and punitive self-relating [11, 23, 26]. Through techniques such as limited reparenting, emotional validation, mindfulness, and self-compassion, MBST may help individuals reduce self-criticism and reconstruct a more stable sense of self-worth [12, 13, 17, 23]. In parallel, MBT seeks to strengthen the capacity to understand one's own and others' mental states, thereby promoting a more coherent and reflective experience of self in interpersonal contexts [4, 21]. From this perspective, the similar short-term outcomes of the two treatments are theoretically plausible.

The overall effectiveness of both interventions is broadly consistent with prior literature suggesting that trauma-informed and schema-focused approaches can reduce shame-related distress and improve self-evaluative functioning [1, 10-13, 17]. This interpretation is also compatible with research showing that trauma-related shame and guilt play an important role in post-traumatic adjustment and may influence self-esteem-related processes [14, 15]. Likewise, mentalization-oriented models have been linked to improved self-understanding and lower vulnerability to internalizing difficulties, particularly in individuals with attachment-related and trauma-related disturbances [20, 21, 27]. Taken together, these findings support the interpretation that both MBST and MBT may be useful for enhancing self-esteem in trauma-exposed women, at least over the time frame examined in the present study.

The higher follow-up scores observed in the MBT group may reflect differences in how treatment gains are maintained after active intervention. A potentially important distinction is that MBT emphasizes the ongoing use of mentalizing capacities in everyday interpersonal situations. Because this capacity can be repeatedly activated in social contexts, it may function as a self-sustaining regulatory resource that supports more stable self-evaluative functioning over time [4, 21, 27]. In this sense, the follow-up advantage observed for MBT may suggest that strengthening reflective

functioning has particular value for maintaining gains in self-esteem after treatment has ended. Nevertheless, this interpretation should remain cautious, as the present study did not directly assess mediating mechanisms such as changes in mentalization, attachment security, or schema mode activation.

In contrast, MBST may produce its effects through emotionally corrective and schema-modifying processes that are strongly facilitated by the therapeutic relationship, especially through limited reparenting and mode work [23, 26]. These interventions may lead to substantial short-term improvement, particularly in individuals with high levels of shame, self-criticism, and unmet emotional needs [11-13]. At the same time, some treatment gains may require a longer consolidation period, booster sessions, or continued practice in daily life to remain maximally stable after treatment termination. This may help explain why the MBST group maintained improvement relative to the control group but did not show the same degree of follow-up advantage observed in the MBT group.

Several considerations warrant caution in interpreting these findings. First, the comparative advantage of MBT over MBST was not evident at posttest and emerged only at follow-up. Second, the follow-up period was limited to three months, which constrains conclusions about longer-term durability. Third, because the study relied on self-report assessment, the findings may have been influenced by response tendencies and cannot clarify the precise mechanisms through which change occurred. Therefore, the present results are better interpreted as preliminary evidence that both interventions are beneficial, with some indication that MBT may support stronger maintenance of self-esteem gains over time. Future longitudinal and mechanism-focused studies are needed to determine whether these differences persist and to clarify the processes through which each intervention influences self-esteem in trauma-exposed women.

Ethical Considerations

This study was derived from the first author's psychology thesis. The study was approved by the Research Ethics Committee of Bushehr Province University of Medical Sciences (Code of Ethics: IR.BPUMS.REC.1404.123), Islamic Azad University, Bushehr Branch, Bushehr, Iran.

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Authors' Contributions

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Conflict of Interest

The authors declared no conflicts of interest.

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