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Effectiveness of Brief Cognitive Behavioral Therapy in Improving Self-Compassion Among Patients with Treatment-Resistant Depression

Narges. Hasani[1], Ahmad. Ravan[2*]

1 M.A. Student, Department of Clinical Psychology, Marv.C., Islamic Azad University, Marvdasht, Iran.
2 Department of Clinical Psychology, Marv.C., Islamic Azad University, Marvdasht, Iran.

Corresponding author email address:
ahmad.ravan@iaularestan.ac.ir

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ABSTRACT

Objective: This study evaluated the effectiveness of brief cognitive behavioral therapy in improving self-compassion among patients with treatment-resistant depression.

Methods and Materials: This quasi-experimental study used a pretest–posttest control-group design. The statistical population included patients with treatment-resistant depression referred to hospitals and psychology clinics in Shiraz, Iran, during 2024–2025. Thirty-four eligible patients with major depressive disorder who had not responded satisfactorily to at least two antidepressant classes after three months of treatment were selected by convenience sampling and randomly assigned to an experimental group (n = 17) and a control group (n = 17). The experimental group received eight 60-minute sessions of brief cognitive behavioral therapy based on Rad's protocol, while the control group remained on a waitlist. Data were collected using the Self-Compassion Scale and analyzed using multivariate analysis of covariance in SPSS-26.

Findings: Brief cognitive behavioral therapy had a significant multivariate effect on self-compassion dimensions (Wilks' Lambda= 0.035, F= 96.103, p<0.001, η^2= 0.665). The intervention significantly increased self-kindness (F= 75.753, p<0.001, η^2= 0.243), common humanity (F= 92.656, p<0.001, η^2= 0.381), and mindfulness (F= 133.924, p<0.001, η^2 = 0.237). It also significantly reduced self-judgment (F = 54.425, p< 0.001, η^2= 0.477), isolation (F= 43.236, p<0.001, η^2= 0.124), and over-identification (F= 34.086, p<0.001, η^2 = 0.267).

Conclusion: Brief cognitive behavioral therapy significantly improved self-compassion in patients with treatment-resistant depression.

Keywords: Cognitive Behavioral Therapy, Depression, Treatment-Resistant, Self-Compassion, Depressive Disorder.

Introduction

Depression is currently the fourth leading cause of disability worldwide, and it is predicted that by 2030 it will become the second, after cardiovascular diseases (Duan et al., 2025). According to the Diagnostic and Statistical Manual of Mental Disorders, a broad spectrum of depressive disorders is recognized, including major depressive disorder, disruptive mood dysregulation disorder, persistent depressive disorder, and substance/medication-induced depressive disorder (Patten, 2025). Despite advances in etiology, psychopharmacology, and neurobiological markers—and the introduction of several classes of antidepressants—a considerable proportion of individuals with major depressive disorder do not respond to antidepressants and exhibit signs of treatment resistance (Levy & Spina, 2025). Treatment-resistant depression refers to an episode of major depression that has not improved even after two pharmacotherapy trials of adequate dose and duration (Little, 2009). There is no general consensus on what accounts for inadequate response in depression, and this form of depression is associated with high relapse rates, increased occupational and social impairment, poorer physical health, functional disruption, and lower quality of life (Tu et al., 2025).

High levels of disruption in psychological processes among individuals struggling with depression foster a tendency toward avoidant coping, which gradually diminishes self-attentiveness and reduces self-compassion (Barel et al., 2025). Self-compassion—an attitude of kindness toward oneself when facing difficulties—helps activate the soothing system and serves as a factor in reducing negative affect and social withdrawal (Olofsson et al., 2026). Recent investigations into psychopathology have identified limitations and deficits in self-compassion among such patients, showing that lower self-compassion is linked with greater mood pathology. Conversely, higher self-compassion is negatively associated with psychopathology and functions as a protective factor against behavioral problems and emotional distress, including depression (Muris et al., 2024).

One of the essential needs of people with depression is access to appropriate therapeutic methods that, by fostering psychological empowerment, reduce vulnerability while creating a more positive outlook for patients and a healthier society (Fanelli et al., 2025). The substantial empirical support for the cognitive-behavioral approach has led health-care guidelines to recommend it as a first-line psychotherapy for depression (Smith & Hewitt, 2024). Recent studies also indicate that cognitive-behavioral therapy (CBT) effectively treats mild, moderate, and severe mental-health symptoms and has gained strong empirical support for a range of disorders in both individual and group formats (Vukosavljević-Gvozden et al., 2024).

Nevertheless, a common strategy for increasing the efficiency of contemporary CBT is to reduce the number of treatment sessions. Its effectiveness has been reported to be comparable to medication in the short term and greater in the long term (Rivelis & Valicenti-McDermott, 2024). Shortening the treatment process and making it cost-effective increases accessibility for those in need. People appreciate reaching results quickly, which can make treatment more acceptable and enhance motivation for subsequent change (Yang et al., 2025). CBT is a structured, time-limited, here-and-now therapy that helps patients—including those with depression—develop strategies to modify maladaptive thought patterns or cognitive distortions, as well as related emotions and behaviors (Saeidi et al., 2021).

Clinical trials and meta-analyses show that CBT techniques—with lower stigma and increased help-seeking (Friedberg et al., 2024)—also play a significant role in reducing self-injurious behaviors (Diefenbach et al., 2025). Yet, despite the theoretical and technical advances of CBT in recent years, epidemiological studies continue to report rising rates of depression and mood problems. This underscores the need for more comprehensive, structured resources grounded in integrated research to convey the vast body of information, techniques, and theory to clinicians, trainees, students, patients with depression, and their families in an appropriate manner—addressing research gaps and identifying the most beneficial psychological treatments that can alleviate the distress of patients with treatment-resistant depression in the shortest possible time. Accordingly, the present study seeks to answer the following question: Is brief cognitive-behavioral therapy

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effective for enhancing self-compassion in individuals with treatment-resistant depression?

Methods and Materials

Study Design

This study was applied in purpose and quasi-experimental in execution, using a pretest–posttest design with a control group. After simple random assignment of two groups (experimental and control), the brief cognitive-behavioral therapy (CBT) program based on Rad's protocol (2012) was delivered to the experimental group in 8 sessions of 60 minutes each. After the program ended, a posttest was administered to both the experimental and control groups. It should be noted that the control group did not receive the brief CBT sessions and remained on a waitlist.

The statistical population comprised all individuals with treatment-resistant depression who presented to hospitals and counseling/psychology clinics in Shiraz in 2024–2025 (1403 SH) and who had a confirmed diagnosis of major depressive disorder (MDD) based on a structured clinical interview, with no satisfactory improvement after 3 months of pharmacotherapy. Using convenience sampling, 34 individuals meeting the inclusion criteria were selected and randomly assigned to two groups of 17 (experimental and control). Regarding the chosen sample size, experimental studies typically recommend a minimum of 30 participants; in the present study, 17 participants per group were considered (allowing for possible attrition) to improve generalizability.

Inclusion criteria were: informed consent and ability to participate; confirmed MDD diagnosis by a qualified specialist; non-response to at least two classes of antidepressants after 3 months of treatment; minimum literacy to complete study instruments; and commitment to completing session homework. Exclusion criteria were as follows: incomplete completion of study instruments; comorbidity of MDD with other psychiatric disorders; concurrent use of antidepressants during participation in the present study; substance abuse or use of any addictive substance; receipt of any psychotherapy in the past 3 months or concurrently with this study; and absence from more than one intervention session.

Instruments

Self-Compassion Scale: This questionnaire was developed by Neff (2003) and contains 26 items and 6 subcomponents: Self-Kindness with items 5, 12, 19, 23, and 26; Self-Judgment (self-criticism) with items 1, 8, 11, 16, and 21; Common Humanity with items 3, 7, 10, and 15; Isolation with items 4, 13, 18, and 25; Mindfulness with items 9, 14, 17, and 22; and Over-Identification with items 2, 6, 20, and 24. Responses are given on a 5-point Likert scale from 1 (never) to 5 (always). The total score ranges from 26 to 130, with higher scores indicating a higher level of self-compassion. Neff (2003) reported Cronbach's alpha coefficients for the subscales ranging from 0.72 to 0.85 and a total test–retest reliability of 0.93 over a two-week interval. Divergent validity was indicated by correlations of −0.55 with the Beck Depression Inventory and −0.65 with the Spielberger Trait Anxiety Inventory, and convergent validity by a correlation of 0.45 with the Satisfaction with Life Scale. Shahbazi et al., (2015) reported an overall Cronbach's alpha of 0.70 and concurrent validity coefficients of −0.45 with the General Health Questionnaire. In the present study, reliability was 0.71 based on Cronbach's alpha.

Table 1

Summary of the Brief CBT Sessions (Rad's 2012)

Session	Content
1	Introduction and treatment contract; psychoeducation on mood problems and suicidal thoughts; problem list; relaxation training.
2	Explanation of automatic thoughts and early signs of stress; practice of cognitive review/reappraisal.
3	Introducing cognitive distortions underpinning automatic thoughts related to stress, tension, and associated emotions.
4	Practicing distraction techniques; establishing baseline; training in progressive muscle relaxation and guided imagery to manage workplace/environmental pressures.
5	Eliciting automatic thoughts about trigger situations; practicing stress management and regulation of other negative emotions.
6	Explaining negative emotions and CBT-based emotion management practices; problem-solving skills training and its relation to maladaptive symptoms.
7	Identifying and challenging dysfunctional attitudes and excessively high standards (maladaptive perfectionism).
8	Explaining termination, and coping with stresses related to ending treatment.

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Ethical Considerations

Participants were asked to attend treatment sessions voluntarily, with the option to discontinue at any time. They were verbally informed that the therapy sessions and questionnaires were part of a research project; their information would remain confidential; and results would be analyzed in aggregate and published as a thesis and articles. They were told not to write their names on the questionnaires. After obtaining verbal consent, the pretest was conducted; the posttest was administered at the end of the intervention. Demographic characteristics were assessed initially. Data were collected via self-report instruments after instructions were explained. This study was approved by the Ethics Committee of Islamic Azad University, Marvdasht Branch, under the code IR.IAU.M.REC.1404.044.

Data Analysis

Collected data were analyzed using descriptive statistics (mean and standard deviation) and inferential statistics (analysis of covariance, ANCOVA), with assumptions checked via the Kolmogorov–Smirnov test, Levene's test, the homogeneity of regression slopes assumption, and linearity. Data were analyzed in SPSS version 26.

Findings and Results

The mean age of the experimental group was 38/11 years, and the mean age of the control group was 37/70 years. In both groups, the highest level of participants' education was non-university level (high-school diploma and below).

Table 2

Mean and standard deviation of the dependent variables by group and assessment phase

Dependent variable	Group	N	Pretest		Posttest	
			Mean	SD	Mean	SD
Self-Kindness	Experimental	17 persons	12/64	1/45	18/52	2/57
	Control	17 persons	13/94	1/56	12/64	2/28
Common Humanity	Experimental	17 persons	11/35	1/57	16/29	2/49
	Control	17 persons	11/23	1/85	10/05	1/39
Mindfulness	Experimental	17 persons	11/23	1/20	16/17	1/55
	Control	17 persons	11/52	1/83	10/47	1/50
Self-Judgment	Experimental	17 persons	12/58	2/00	9/00	2/12
	Control	17 persons	12/76	2/07	13/26	1/90
Isolation	Experimental	17 persons	12/47	2/23	9/11	1/49
	Control	17 persons	12/70	2/16	13/17	2/15
Over-Identification	Experimental	17 persons	12/05	1/47	8/94	1/74
	Control	17 persons	32/72	9/92	03/79	11/96
Self-Compassion	Experimental	17 persons	13/41	2/23	14/17	1/42
	Control	17 persons	56/75	11/91	27/74	12/01

In Table 2, the descriptive statistics (mean and standard deviation) of the dependent variables are presented by assessment phase (pretest and posttest) for the experimental and control groups. According to the results, in the experimental groups, there is a marked improvement from pretest to posttest in the scores of the studied variables; however, in the control group, no noticeable change from pretest to posttest was observed in these variables.

Prior to conducting the analysis of covariance, to examine the assumption of normality of score distributions in the population, the Shapiro–Wilk test and the indices of skewness and kurtosis were used. The results show that for all dependent variables the significance level is greater than 0/05 (p>0/05), therefore the distribution of scores in the population is normal. In addition, the skewness and kurtosis values of the study variables fall within the range (−2 to 2), indicating that the variables have normal skewness and kurtosis. Therefore, the use of analysis of covariance for the study data is permissible. It should be noted that when the sample size is fewer than 50 participants, it is preferable to rely on the Shapiro–Wilk test as the criterion. To examine the assumption of homogeneity of variances, Levene's test was used, and its results indicate that Levene's assumption is confirmed for all dependent variables of the study; due to random assignment of the two groups and an adequate sample size, analysis of variance can be used to test the hypotheses. Moreover, since the F test is robust against a moderate degree of

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heterogeneity of variances—especially when samples are of equal size—the use of analysis of variance is feasible.

To assess the assumption of homogeneity of the variance–covariance matrices, Box's M test was used. The results show that since the obtained significance level is greater than 0/05 (Baxs M=10/073, F=1/507, p=0/171), the study data do not violate the equality of variance–covariance matrices. Because the variance–covariance matrices are homogeneous, analysis of covariance can be used in this study.

Table 3

Results of multivariate analysis of covariance (MANCOVA) on self-compassion

Test type	Value	F test	Significance level	Effect size	Statistical power
Pillai's Trace	0/965	96/103	0/000	0/665	0/987
Wilks' Lambda	0/035	96/103	0/000	0/665	0/987
Hotelling's Trace	27/458	96/103	0/000	0/665	0/987
Largest Root	27/458	96/103	0/000	0/665	0/987

The results in Table 3 indicate that Wilks' Lambda (F=103/96, P=0/000) is significant. The findings show that, controlling for the pretest, there is a significant difference between the experimental and control participants in the posttest of the dependent variables (self-compassion dimensions). Accordingly, it can be stated that at least one of the aforementioned dependent variables shows a significant difference, and the effect size indicates that 66/5 percent of the difference between the two groups is attributable to the experimental program (brief cognitive-behavioral therapy). Next, it is necessary to examine whether the dependent variables under study are individually affected by the independent variable (brief cognitive-behavioral therapy). For this purpose, multivariate analysis of covariance (MANCOVA) was used, the results of which are shown in Table 4.

Table 4

Between-subjects effects of analysis of covariance on the self-compassion posttest

Source	Variable	SS	df	MS	F statistic	P	η	Statistical power
Group membership	Self-Kindness	333/857	1	333/857	75/753	0/000	0/243	0/996
	Common Humanity	276/223	1	276/223	92/656	0/000	0/381	1/000
	Mindfulness	261/491	1	261/491	133/924	0/000	0/237	0/889
	Self-Judgment	153/946	1	153/946	54/425	0/000	0/477	1/000
	Isolation	106/653	1	106/653	43/236	0/000	0/124	0/698
	Over-Identification	135/904	1	135/904	34/086	0/000	0/267	1/000
Error	Self-Kindness	114/587	26	4/407				
	Common Humanity	77/511	26	2/981				
	Mindfulness	50/766	26	1/953				
	Self-Judgment	73/544	26	2/829				
	Isolation	64/135	26	2/467				
	Over-Identification	103/663	26	3/987				

The results of the multivariate analysis of covariance (MANCOVA) in Table 4 show that brief cognitive-behavioral therapy (controlling the effect of the pretest as a covariate on the posttest) had a significant effect, at the 0/05 level, on reducing scores for Self-Judgment, Isolation, and Over-Identification and on increasing scores for Self-Kindness, Common Humanity, and Mindfulness. The multivariate analysis of covariance results in Table 4 in the Findings section indicate that brief cognitive-behavioral therapy had a significant effect at the 0/05 level on reducing Self-Judgment (P=0/000, η=0/477), Isolation (P=0/000, η=0/124), and Over-Identification (P=0/000, η=0/267), and on increasing Self-Kindness (P=0/000, η=0/243), Common Humanity (P=0/000, η=0/381), and Mindfulness (P=0/000, η=0/237).

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Discussion and Conclusion

This finding from the present study is consistent with and aligned with the results of some previous studies such as Bagherian et al., (2025), Garland, (2020), Karimi et al. (2023), Khazraee et al, (2023), Kurtoglu & Basgul, (2023), Rodrigues et al., (2025), and Heshmati et al. (2023).

In explaining this finding, it can be said that in cognitive-behavioral therapy individuals are helped to identify and modify negative attitudes, thoughts, and behaviors that may contribute to the course of the disorder. In addition, individuals are taught to overcome problems and prevail over situations they previously regarded as unsolvable. In fact, cognitive emotion regulation is characterized by processes through which people can control what emotions they have and when they express them. Thus, cognitive-behavioral therapy, by changing and correcting thinking and behavior, alters clients' negative feelings and, by increasing control over their emotions, empowers them to cope with life events. In essence, brief cognitive-behavioral therapy prevents destructive beliefs from becoming entrenched within the individual's cognitive systems, and clients come to realize that by having purpose and meaning in life and a sense of belonging and hope—alongside managing feelings and controlling emotions in stressful life conditions and perceiving greater control over oneself and ruminations—they can bring under mastery unpredictable situations or thoughts related to past memories and psychological pain and sustain less harm, pain, and suffering in forthcoming stressful events. In this way, the individual gains the ability, through moderating self-judgment and distorted thinking, to face the self to some extent without judgment and blame, thereby showing improvement in self-compassion.

In another explanation for the above finding, the aim of brief cognitive-behavioral therapy is to correct irrational beliefs, dysfunctional beliefs, erroneous interpretations, and cognitive errors; enhance the sense of control over life; facilitate constructive self-talk; and strengthen coping skills. Brief cognitive-behavioral therapy emphasizes that cognitive processes are as important as environmental effects. Accordingly, this intervention—combining cognitive and behavioral approaches—through structured discussions and organized behavioral assignments, helps individuals with medication resistance and mood symptoms change distorted thinking patterns and maladaptive behaviors. Brief cognitive-behavioral therapy is effective in creating and increasing capabilities such as decision-making, fostering interest and motivation, accepting responsibility, positive relationships with oneself, others, and the surrounding environment, facilitating self-esteem, and increasing problem-solving skills and emotional self-regulation. Accordingly, this intervention, by increasing control and emotional self-regulation, reduces negative mood and emotional experiences and, on the other hand, by drawing on value structures and self-efficacy, improves self-compassion.

Although the experimental and control groups were to some extent similar in characteristics due to random assignment and statistical controls enabled comparisons between the two groups, limiting the sample to patients with treatment-resistant depression who presented to hospitals and psychology clinics in the city of Shiraz, and the limited number of participants—stemming from methodological constraints of this type of study—means that caution should be exercised in generalizing the results to other groups in the community, especially the category of depressive disorders. The individuals studied may have been influenced by the response environment when answering the questions, and the responses provided may have been less precise. Despite the researcher's efforts to reduce the challenges and problems in this regard, some challenges—such as personality structures, the strength of patients' defense mechanisms, and family and cultural backgrounds—are not controllable and may have affected the results. Other limitations faced by the present study, besides the use of nonrandom (convenience) sampling, included not examining treatment effects at follow-up due to lack of cooperation from patients and clinic officials, as well as lack of time and financial support to continue the work. Meanwhile, in studies outside Iran, follow-up periods of 1 to 6 years have been implemented.

It is suggested that in future studies, to assess the research variables, in addition to questionnaires, other methods such as interviews also be used. Moreover, given the study's limitations related to selecting a follow-up period due to lack of cooperation from patients and the treatment center, it is recommended that future studies include a follow-up phase so that the durability of treatment effects over time can be examined and

better conclusions reached. It is also suggested, in view of the consistency between the results of this study and prior research, that psychologists and those who work with individuals resistant to treatment, while becoming fully familiar with the exercises and techniques of the brief cognitive-behavioral approach for psychological, behavioral, and emotional constructs in these patients, strive to implement it correctly and more extensively. Researchers are also advised to apply the study topic to other chronic medical and psychosomatic patients.

Based on the study's results indicating the effectiveness of brief cognitive-behavioral therapy on self-compassion, it is recommended that—at the city level and with the help of officials and the engagement of specialists experienced in this approach—workshops be held so that, alongside increasing public mental health literacy, an effective step is taken toward preventing others from developing psychological problems and reducing psychological dysfunction. In addition, mental health service centers can equip themselves with exercises drawn from this approach to assist clients who struggle with self-compassion.

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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. 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.

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Authors' Contributions

All authors equally contribute to this study.

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