

Comparison of the Effectiveness of Self-Compassion Therapy and Trauma-Focused Cognitive Behavioral Therapy on Self-Criticism and Resilience in Individuals with Posttraumatic Stress Disorder Related to the Iraqi Civil War

Ahmed. Radhi Khaleefah¹, Sajjad. Basharpour^{2*}, Nader. Hajloo², Akbar. Atadokht²

¹ PhD Student, Department of Psychology, Faculty of Educational Sciences and Psychology, Mohagheg Ardabili University, Ardabil, Iran

² Professor, Department of Psychology, Faculty of Educational Sciences and Psychology, Mohagheg Ardabili University, Ardabil, Iran

* Corresponding author email address: basharpour_sajjad@gmail.com

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ABSTRACT

Purpose: The present study aimed to compare the effectiveness of self-compassion therapy and trauma-focused cognitive behavioral therapy (TF-CBT) in reducing self-criticism and enhancing resilience among individuals with war-related posttraumatic stress disorder (PTSD).

Methods and Materials: This experimental study employed a multigroup pretest-posttest design. A total of 60 individuals with PTSD related to the Iraqi Civil War were randomly assigned to two experimental groups (self-compassion therapy and trauma-focused cognitive behavioral therapy) and one control group (waiting-list control). The research instruments included the Mississippi Scale for Combat-Related PTSD, the Levels of Self-Criticism Scale (LOSC), and the Connor-Davidson Resilience Scale (CD-RISC). Data were analyzed using multivariate analysis of covariance (MANCOVA) and the Bonferroni post hoc test in SPSS version 26.

Findings: The results indicated that both interventions significantly reduced self-criticism and improved resilience ($p < .05$). The Bonferroni post hoc test further showed that trauma-focused cognitive behavioral therapy was significantly more effective than self-compassion therapy ($p < .05$).

Conclusion: The findings demonstrated that both self-compassion therapy and trauma-focused cognitive behavioral therapy significantly reduced self-criticism and enhanced resilience among individuals with war-related PTSD, whereas no significant changes were observed in the control group. Furthermore, comparison of the two interventions indicated that trauma-focused cognitive behavioral therapy was more effective than self-compassion therapy in reducing self-criticism and improving resilience.

Keywords: self-compassion therapy, trauma-focused cognitive behavioral therapy, self-criticism, resilience, war-related posttraumatic stress disorder

1. Introduction

War and armed conflict represent some of the most severe forms of collective adversity because they expose individuals and communities to repeated, uncontrollable, and often prolonged threats to life, bodily integrity, family cohesion, social stability, and economic security. Unlike many discrete traumatic events, war-related trauma frequently occurs in an environment in which danger is recurrent and accompanied by displacement, bereavement, witnessing violence, destruction of homes and communities, loss of occupational and social roles, and continuing uncertainty about personal and family safety. These cumulative exposures can produce enduring psychological consequences long after the immediate threat has subsided. Research conducted across conflict-affected populations has consistently demonstrated a substantial burden of mental disorders, particularly posttraumatic stress disorder (PTSD), depression, and anxiety, among civilians and other individuals exposed to armed violence (Carta et al., 2015; Priebe et al., 2010). Global estimates further indicate that conflict-affected populations experience considerably elevated rates of common and severe mental disorders compared with populations not exposed to organized violence (Charlson et al., 2019). Meta-analytic evidence among adult war survivors has similarly shown that PTSD and major depression constitute major contributors to the long-term psychological burden of war, affecting large numbers of individuals worldwide (Hoppen & Morina, 2019).

PTSD is particularly important in war-exposed populations because its symptoms may persist well beyond the original traumatic exposure and substantially interfere with interpersonal, occupational, emotional, and social functioning. Civilian survivors who remain in war-affected regions can continue to experience traumatic reminders, environmental insecurity, and limited access to psychological care, which may complicate both symptom remission and psychological recovery (Morina et al., 2018). Recent evidence from communities affected by contemporary armed conflict reinforces the continuing magnitude of this problem. High levels of posttraumatic stress have been documented among populations living in war-affected regions, including communities exposed to armed conflict in Ethiopia (Tinsae et al., 2024), while studies conducted during the Russia–Ukraine war have demonstrated substantial associations between war-related stressors and both PTSD and complex PTSD

symptomatology (Lotzin et al., 2023). These findings are especially relevant to individuals who have experienced prolonged civil conflict, where exposure may involve repeated rather than singular traumatic events. Accordingly, psychological consequences of war should be understood not merely as transient responses to extraordinary stress, but as potentially persistent patterns of emotional, cognitive, behavioral, and physiological disturbance requiring focused therapeutic intervention.

The psychological effects of war are nevertheless heterogeneous. Not all individuals exposed to severe trauma develop persistent PTSD, and survivors vary substantially in their capacity to maintain or regain adaptive functioning. Contemporary models therefore increasingly consider both vulnerability processes and protective resources when explaining responses to traumatic adversity. Resilience is central to this perspective and generally refers to the dynamic capacity to adapt successfully, recover, or sustain meaningful functioning in the presence of significant stress or adversity. Rather than representing a fixed personality trait, resilience is increasingly conceptualized as a multidimensional and developmental process shaped by personal capacities, interpersonal relationships, environmental resources, coping strategies, and the nature of the stressor itself (Masten, 2018). In conditions of war, terrorism, forced migration, and prolonged uncertainty, resilience can influence whether exposure results in persistent psychopathology or whether individuals are able to reorganize psychological resources and progressively restore functioning (Schwarzer, 2024). Evidence from war-exposed refugees has shown that resilience may moderate the association between traumatic exposure and PTSD symptoms, suggesting that resilience can operate as an important buffer against the psychological consequences of severe trauma (Fino et al., 2020).

Resilience is also clinically relevant because it is potentially modifiable. Psychological interventions may enhance resilience by improving emotion regulation, cognitive flexibility, perceived competence, social connectedness, self-efficacy, acceptance, and adaptive coping. Research involving young people exposed to the Ukraine–Russia war has emphasized the role of interpersonal and psychological processes in developing resilience under conditions of ongoing conflict (Giordano et al., 2024). Other studies suggest that resilience is linked to cognitive processing of negative experiences and may modify the relationship between earlier victimization and subsequent negative cognitive biases (Wang et al., 2023). In

non-war populations, self-compassion and related contemplative dispositions have also been associated with stronger resilience and better mental health (Clarke & Hartley, 2025), while psychological empowerment and self-compassion have been identified as relevant resources for resilience among women managing multiple demanding roles (Weliangan et al., 2024). Network-based research has further demonstrated meaningful connections among self-care, self-compassion, stress, and resilience, reinforcing the possibility that interventions directed toward compassionate self-relating may contribute to broader adaptive functioning (Pank et al., 2025). Compassion-based therapy has likewise been reported to improve resilience in caregiving populations facing persistent stress (Rezavandi et al., 2025). Thus, enhancing resilience may constitute an important therapeutic objective for people living with war-related PTSD rather than focusing exclusively on symptom reduction.

Another psychological process with particular relevance to PTSD is self-criticism. Self-criticism broadly involves a persistent tendency to evaluate oneself harshly, focus on perceived inadequacies or failures, and respond to personal difficulties with blame, judgment, shame, or hostility. Although definitions vary across theoretical traditions, contemporary reviews emphasize that self-criticism is a multidimensional construct involving negative self-evaluation, punitive internal responding, perceived failure to meet personal standards, and unfavorable comparison with others (Zaccari et al., 2024). In clinical contexts, elevated self-criticism can intensify emotional distress because individuals not only experience painful symptoms or memories but also judge themselves negatively for having those reactions. Following trauma, survivors may criticize themselves for perceived weakness, inability to prevent the traumatic event, emotional responses during or after the event, or perceived failures to recover. Such internal responses may contribute to shame, guilt, avoidance, and persistent negative beliefs about the self.

Evidence increasingly indicates that self-criticism is relevant to the maintenance and severity of trauma-related psychopathology. Among women exposed to intimate partner violence, self-criticism has been associated with PTSD, whereas self-acceptance and self-efficacy appear to play potentially protective roles (Crapolicchio et al., 2021). Research examining trauma histories and posttraumatic symptoms in people with experiences of homelessness has similarly highlighted self-criticism and self-compassion as potential mediating psychological mechanisms connecting

adversity with later posttraumatic symptoms (Igoe, 2024). Trauma-related appraisals and difficulties in emotion regulation have also been linked with PTSD symptoms, with self-compassion emerging as a potentially protective factor (Barlow et al., 2017). Clinical research further suggests that interventions capable of modifying rigid negative self-evaluation can reduce self-criticism. Cognitive-existential therapy, for example, has been associated with reductions in psychological pain and self-criticism among women with PTSD symptoms (Solgi & Ghazi, 2022), while schema therapy has demonstrated beneficial effects on self-criticism and emotional self-regulation in depressed women (Gholizadeh, 2022). Enhanced cognitive behavioral therapy has also been reported to improve self-criticism in adolescents experiencing body-image difficulties (Rahmani et al., 2025). The importance of self-criticism is not restricted to trauma-related disorders; meta-analytic evidence across disordered eating research also demonstrates a robust relationship between psychopathology, self-criticism, and lower self-compassion (Paranjothy & Wade, 2024). Collectively, these findings suggest that reducing self-criticism may represent a clinically meaningful pathway through which psychological interventions improve emotional functioning.

Self-compassion provides a theoretically important counterprocess to self-criticism. Within Neff's conceptualization, self-compassion involves responding to personal suffering with kindness rather than harsh self-judgment, recognizing painful experiences as part of shared humanity rather than as evidence of isolation or defectiveness, and maintaining mindful awareness of distress rather than becoming overidentified with painful thoughts and emotions (Neff, 2011). Contemporary theoretical and empirical developments have further established self-compassion as a multidimensional psychological resource associated with emotional regulation, adaptive coping, psychological well-being, and reduced psychopathology (Neff, 2023). From a trauma perspective, self-compassion may be particularly valuable because traumatic experiences often generate shame, guilt, perceived helplessness, and negative self-beliefs. By promoting a less punitive and more accepting orientation toward internal experience, self-compassion may reduce secondary distress arising from self-condemnation while increasing willingness to approach difficult memories and emotions.

The relevance of self-compassion to trauma has received growing empirical support. A systematic review of the

literature on self-compassion, trauma, and PTSD identified consistent relationships between greater self-compassion and more favorable trauma-related psychological outcomes (Winders et al., 2020). More specifically, self-compassion may influence PTSD through its effects on trauma appraisals and emotion regulation, both of which are central to the persistence of posttraumatic symptoms (Barlow et al., 2017). Longitudinal evidence also suggests that self-criticism, self-compassion, psychological flexibility, and mental health are dynamically interrelated over time, supporting the clinical relevance of modifying how individuals respond to themselves during periods of psychological distress (Wong et al., 2025). Importantly, self-compassion is not merely correlated with lower distress but can be deliberately cultivated through structured therapeutic interventions. A systematic review and meta-analysis found that self-compassion-related interventions produce meaningful reductions in self-criticism, providing direct support for their therapeutic application when harsh self-evaluation is a central clinical problem (Wakelin et al., 2022). Intervention studies have similarly demonstrated reductions in self-criticism following self-compassion therapy among graduate students (Hajrezaei & Hokmabadi, 2024) and improvements in self-criticism and shame following mindful self-compassion training among mothers of children with autism spectrum disorder (Ameri et al., 2025). These findings provide a strong rationale for examining self-compassion-based treatment among individuals with war-related PTSD, particularly when self-criticism and diminished resilience are prominent difficulties.

Although self-compassion therapy directly targets a compassionate relationship with the self, trauma-focused cognitive behavioral therapy addresses another set of mechanisms highly relevant to PTSD. Trauma-focused cognitive behavioral approaches generally aim to modify maladaptive trauma-related beliefs, reduce avoidance, improve emotion-regulation and coping skills, facilitate structured processing of traumatic memories, and weaken the association between trauma reminders and overwhelming emotional responses. Trauma-focused cognitive behavioral interventions constitute an important evidence-based family of treatments for PTSD and are supported by a substantial clinical literature (Forbes et al., 2020). Their therapeutic rationale is particularly relevant to war-related PTSD because individuals exposed to armed conflict may develop persistent beliefs concerning danger, guilt, helplessness, mistrust, personal inadequacy, and permanent psychological damage. By helping patients

identify and modify distorted interpretations of trauma while progressively processing trauma-related memories, these interventions may reduce posttraumatic distress and potentially alter self-critical cognitions.

An important issue in treating people affected by war is that traumatic threat may not always be entirely historical. Some individuals continue to face political instability, displacement, insecurity, family separation, or ongoing reminders of violence. This raises questions about whether trauma-focused interventions can be used effectively when external threat has not been completely eliminated. A systematic review of trauma-focused cognitive behavioral therapies administered under conditions of ongoing threat nevertheless found evidence supporting their applicability, although treatment must account for realistic danger and contextual complexity (Ennis et al., 2021). Related clinical work with veterans has also demonstrated that trauma-focused approaches such as narrative exposure therapy can improve posttraumatic symptoms and associated emotional outcomes (Khorsand Nobahar et al., 2023). At the same time, contemporary PTSD research is expanding beyond conventional psychotherapy to include increasingly individualized interventions targeting neurobiological mechanisms, including personalized neurocircuitry-guided neuromodulation approaches (van Rooij et al., 2026). Such developments reflect the broader recognition that PTSD is a multidimensional disorder involving cognitive, affective, behavioral, interpersonal, and neurobiological processes; nevertheless, scalable psychological interventions remain essential, particularly in populations affected by large-scale armed conflict.

Despite substantial evidence supporting both compassion-based and trauma-focused interventions, the mechanisms through which they influence recovery are not identical. Self-compassion therapy emphasizes reduction of harsh self-judgment, acceptance of suffering, compassionate emotional regulation, and development of a supportive internal stance, whereas trauma-focused cognitive behavioral therapy more directly addresses trauma-related cognitions, avoidance, emotional responses, coping behaviors, and processing of traumatic memories. This distinction is clinically meaningful because self-criticism and resilience may respond differently to each therapeutic pathway. Self-compassion interventions may be especially well suited to reducing shame-based and punitive self-evaluation, whereas trauma-focused CBT may produce broader changes by directly modifying trauma-related beliefs and improving mastery over trauma reminders.

Conversely, the increased emotional safety and self-acceptance generated by self-compassion may strengthen resilience by helping individuals tolerate distress without escalating self-attack. Existing research supports both possibilities, but direct comparisons remain limited, particularly among survivors of war-related PTSD.

This gap is especially important because treatment selection should ideally be informed not only by whether an intervention reduces PTSD symptoms, but also by whether it improves psychological processes that may influence long-term adjustment. Reducing self-criticism can decrease an internal source of chronic emotional threat, whereas enhancing resilience may improve the individual's capacity to manage future stressors and maintain adaptive functioning. Given the enduring psychological consequences of war exposure, the established relevance of self-criticism to trauma-related distress, the protective role of resilience, and accumulating evidence supporting both self-compassion-based and trauma-focused cognitive behavioral interventions, a direct comparison of these approaches may provide clinically useful evidence for the psychological rehabilitation of individuals affected by armed conflict.

Therefore, the present study aimed to compare the effectiveness of self-compassion therapy and trauma-focused cognitive behavioral therapy in reducing self-criticism and enhancing resilience among individuals with posttraumatic stress disorder related to the Iraqi Civil War.

2. Methods and Materials

2.1. Study Design and Participants

The present study employed an experimental multigroup pretest–posttest design with two active intervention groups and one waiting-list control group. The independent variable was the type of intervention, operationalized at three levels: self-compassion therapy, trauma-focused cognitive behavioral therapy (TF-CBT), and waiting-list control. The primary dependent variables were self-criticism and resilience, while war-related posttraumatic stress disorder (PTSD) symptoms were assessed to establish participants' eligibility and clinical status. The target population consisted of individuals experiencing PTSD associated with exposure to the Iraqi Civil War who had attended the Veterans and Martyrs Affairs Organization in Babol during 2025–2026. After obtaining the required authorization from the university ethics committee and the relevant administrative authorities, purposive sampling was used to identify

potential participants. Initially, 250 individuals referred by the Veterans and Martyrs Affairs Organization were screened and completed the research questionnaires in the presence of the researcher. Individuals who met the diagnostic and questionnaire-based eligibility criteria were then considered for participation in the experimental phase. PTSD diagnosis was established according to the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and was confirmed by a psychiatrist. From the eligible individuals, 60 participants were selected and subsequently assigned through simple random allocation, using a random-number procedure, to the self-compassion therapy group, the TF-CBT group, or the waiting-list control group, with 20 participants allocated to each condition. Random assignment was used to minimize selection bias and improve baseline comparability among the three groups. The inclusion criteria consisted of direct or indirect exposure to war and its consequences, fulfillment of the diagnostic criteria for war-related PTSD, obtaining a score consistent with clinically significant PTSD symptoms on the designated screening measure, provision of written informed consent, and willingness to participate actively in the intervention until its completion. The exclusion criteria were absence from more than two treatment sessions and voluntary withdrawal from treatment or the study at any stage. Before implementation of the interventions, all three groups completed the pretest measures of PTSD symptoms, self-criticism, and resilience. The two experimental groups subsequently received their respective interventions over eight sessions, delivered twice weekly, whereas the control group received no psychological intervention during the study period and remained on a waiting list. Immediately following completion of the intervention phase, all three groups completed the same measures as posttest assessments. Ethical principles were observed throughout the study, including confidentiality of participants' personal and clinical information, voluntary participation, the right to withdraw without penalty at any stage, protection of participants' psychological welfare, and provision of the relevant psychological intervention to members of the waiting-list control group after completion of the research procedures.

2.2. Instruments

The Mississippi Scale for Combat-Related PTSD was used to assess the severity of posttraumatic stress symptoms associated with war exposure. According to the source

information used in the present study, the scale was developed on the basis of diagnostic criteria for posttraumatic stress disorder and was introduced by Norris and Reed (1997), with its Persian version subsequently validated by Goodarzi (2003). The instrument consists of 39 items covering several domains of posttraumatic symptomatology, including intrusive memories, interpersonal difficulties, impaired emotional regulation, and depressive-related manifestations. The intrusive-memory domain includes Items 4, 7, 13, 14, 18, 29, 33, 36, 37, and 39; the interpersonal-difficulties domain includes Items 1, 5, 6, 19, 22, 28, 30, 35, and 38; the emotional-control domain includes Items 3, 16, 20, 23, 24, 25, 26, 27, 31, and 32; and the depression-related domain includes Items 2, 8, 9, 10, 11, 12, 15, 17, 21, and 34. Responses are scored on a 5-point Likert-type scale, with scoring direction reversed for designated items. Item scores are summed to obtain an overall index of PTSD symptom severity, with higher total scores representing greater severity of posttraumatic symptomatology. Completion of the scale requires approximately 15 minutes. The instrument has demonstrated strong psychometric properties, including a reported test-retest reliability coefficient of .97, Cronbach's alpha of .94, sensitivity of .93, and classification efficiency of .90. In the Persian validation study, Goodarzi (2003) reported an internal consistency coefficient of .92, split-half reliability of .92, one-week test-retest reliability of .91, and a coefficient of .82 based on comparison with a parallel measure. More recently, Khorsand Nobahar et al. (2023) reported a Cronbach's alpha coefficient of .91, further supporting the reliability of the scale for the assessment of PTSD-related symptoms.

The Levels of Self-Criticism Scale (LOSC) was administered to assess participants' tendency toward negative self-evaluation. The scale was developed by Thompson and Zuroff (2004) and conceptualizes self-criticism as comprising two related but distinguishable dimensions: internalized self-criticism and comparative self-criticism. Internalized self-criticism is assessed by Items 1, 3, 5, 7, 9, 11, 13, 15, 17, and 19 and refers to negative evaluation of the self in relation to personally established internal standards, expectations, and ideals. Individuals with elevated internalized self-criticism tend to perceive themselves as inadequate or unsuccessful when they fail to meet their own expectations, irrespective of direct comparisons with other individuals. Comparative self-criticism is assessed by Items 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 21, and 22 and refers to a negative view of the self

derived from unfavorable comparison with other people. This dimension reflects a tendency to perceive others as superior and oneself as deficient, and it may involve an interpersonal component characterized by perceived competition, inferiority, or hostility (Thompson & Zuroff, 2004). The scale consists of 22 items rated on a 7-point Likert-type response format ranging from 0 ("not at all descriptive of me") to 6 ("describes me very well"). Higher scores indicate greater levels of self-criticism. In the Persian psychometric evaluation reported by Gholizadeh (2022), Cronbach's alpha coefficients were .89 for internalized self-criticism, .91 for comparative self-criticism, and .90 for the total scale, demonstrating satisfactory internal consistency. The content validity of the measure was also reported to have been confirmed through expert evaluation.

The Connor-Davidson Resilience Scale (CD-RISC) was used to assess participants' capacity to adapt successfully in the face of stress, adversity, and potentially traumatic circumstances. The scale was developed by Connor and Davidson (2003) and contains 25 items rated on a 5-point Likert-type scale ranging from 0 ("not true at all") to 4 ("true nearly all of the time"). The original factor structure includes personal competence and tenacity, assessed by Items 10, 11, 12, 16, 17, 23, 24, and 25; trust in one's instincts and tolerance of negative affect, assessed by Items 6, 7, 14, 15, 18, 19, and 20; positive acceptance of change and secure relationships, assessed by Items 1, 2, 4, 5, and 8; control, assessed by Items 13, 21, and 22; and spiritual influences, assessed by Items 3 and 9. Item scores are summed to produce a total score ranging from 0 to 100, with higher scores indicating greater resilience. Although the original development study provided evidence for a multidimensional structure, Connor and Davidson (2003) emphasized the utility of the total resilience score because evidence for the reliability and validity of the individual subscales was less definitive. The scale has demonstrated satisfactory internal consistency, test-retest reliability, and convergent and discriminant validity (Connor & Davidson, 2003). Psychometric studies conducted with Persian-speaking samples have also supported its reliability and validity. Besharat et al. (2007) reported satisfactory psychometric properties for the Persian version, and Hagh Ranjbar et al. (2011) reported a Cronbach's alpha coefficient of .84, indicating acceptable internal consistency. In the present study, the overall CD-RISC score was therefore used as the principal indicator of resilience.

2.3. Interventions

The first experimental group received self-compassion therapy based on the therapeutic framework proposed by Neff (2011). The intervention consisted of eight 75-minute group sessions delivered twice weekly. The first session introduced the general concept of compassion-based intervention, the role of compassion in psychological well-being, the fundamental principles of a compassionate approach, and the influence of compassion on emotional and neuropsychological regulatory systems. Particular attention was given to the regulation of major emotional systems and the interaction between evolutionarily older threat-related processes and more recently developed higher-order cognitive processes. The second session focused on mindfulness practice, awareness of suffering in the present moment, and development of a compassion-based case formulation involving the identification of current symptoms, contextual factors contributing to psychological difficulties, the influence of previous life experiences, principal threats and fears, safety strategies, and the unintended consequences of maladaptive coping responses. The third session included compassionate-self imagery, imagery involving compassion toward others and receiving compassion from others, safe-place imagery, two-chair exercises, and techniques designed to establish greater flexibility and compassionate communication among different aspects of the self while strengthening empathy, sympathy, and sensitivity toward personal suffering. The fourth session addressed the development of a compassionate identity and cultivation of a compassionate mindset, with emphasis on systematic training of a kind and supportive internal orientation. The fifth session focused on managing difficult emotions and increasing awareness of participants' persistent struggles with anxiety, depressive affect, psychological pain, and distress associated with difficult interpersonal experiences. Creative hopelessness and a non-blaming perspective were introduced to reduce fusion with shame and harsh self-judgment. The sixth session emphasized living more meaningfully through clarification of valued goals, identification of personally meaningful life directions, and selection of health-promoting and self-caring behavioral pathways. The seventh session addressed transformation of interpersonal relationships, recognition and reduction of experiential avoidance and excessive control strategies, cultivation of compassionate behaviors involving wisdom, strength, courage, and kindness, and active engagement in difficult or fear-evoking

activities through behavioral activation. The eighth and final session focused on identifying and modifying persistent negative biases, ending the internal struggle with unwanted experiences, strengthening awareness of personal resources and positive aspects of life, and helping participants formulate meaningful goals across major life domains, including occupational functioning, family relationships, social life, education, physical health, spirituality, community participation, recreation, and leisure. The final session also included consolidation of acquired skills and preparation for maintaining therapeutic gains after termination of treatment (Neff, 2011).

The second experimental group received trauma-focused cognitive behavioral therapy based on the treatment framework described by Cohen et al. (2006). The protocol consisted of eight 60-minute group sessions delivered twice weekly. The first session was devoted to introducing group members and the therapist, establishing expectations regarding attendance and participation, discussing group rules and confidentiality, providing an overview of the treatment rationale, and completing baseline assessments. The second session focused on psychoeducation concerning trauma, PTSD symptoms, common psychological and physiological responses to traumatic experiences, and preparation for trauma-focused therapeutic work. The third session addressed affect-modulation skills, including identification and labeling of emotions, rating the intensity of emotional responses, increasing awareness of trauma-related affective states, and learning strategies for regulating emotional reactions when trauma-related distress emerged. The fourth session focused on relaxation and physiological self-regulation techniques, particularly progressive muscle relaxation and diaphragmatic or deep breathing. Participants were introduced to the rationale underlying relaxation training and practiced techniques intended to reduce physiological arousal associated with trauma reminders. The fifth session emphasized cognitive coping skills and the relationships among thoughts, emotions, and behavioral responses. Participants learned to distinguish thoughts from feelings and behavioral consequences, identify maladaptive automatic thoughts, and use cognitive interruption and alternative thinking strategies when distressing cognitions occurred. The sixth and seventh sessions were devoted primarily to cognitive processing of trauma-related experiences and modification of maladaptive trauma-related cognitions. Participants were encouraged to construct and describe a trauma narrative, identify cognitive distortions embedded in their interpretations of the traumatic

experience, recognize automatic negative thoughts, challenge dysfunctional beliefs, generate more balanced and adaptive responses, and develop effective coping strategies for use when confronted with trauma reminders. Techniques for strengthening perceived mastery and self-regulation following activation of trauma memories were also practiced. The eighth session involved sharing and processing the trauma narrative as therapeutically appropriate, exploring emotional responses and perceived consequences associated with disclosure, reviewing strategies for enhancing personal and environmental safety, consolidating treatment goals and skills, preparing for future trauma reminders, summarizing treatment progress, terminating the intervention, and completing posttest assessments. Throughout the protocol, emphasis was placed on gradual cognitive and emotional processing of trauma while simultaneously strengthening coping, affect-regulation, relaxation, and safety-related skills (Cohen et al., 2006).

2.4. Data Analysis

Data were analyzed using IBM SPSS Statistics version 26. Descriptive statistics, including means and standard deviations, were calculated to summarize the study variables separately for the self-compassion therapy, TF-CBT, and waiting-list control groups at the pretest and posttest stages. Prior to inferential analyses, the data were examined with respect to the assumptions required for multivariate analysis of covariance, including the distribution of dependent

variables, identification of potentially influential outliers, linear relationships among covariates and dependent variables, homogeneity of regression slopes, equality of error variances, and equality of covariance matrices across groups. Multivariate analysis of covariance (MANCOVA) was then performed to determine whether the three study conditions differed significantly in posttest self-criticism and resilience after controlling for corresponding pretest scores. The intervention condition served as the fixed independent factor, posttest self-criticism and resilience scores were entered as dependent variables, and their respective baseline scores were included as covariates. When the omnibus multivariate and subsequent univariate effects were statistically significant, Bonferroni-adjusted post hoc comparisons were conducted to determine which groups differed from one another and, specifically, whether self-compassion therapy and TF-CBT differed in their effects relative to each other and to the waiting-list control condition. All statistical tests were two-tailed, and the level of statistical significance was set at $p < .05$.

3. Findings and Results

Descriptive statistics were first calculated to examine changes in self-criticism and resilience across the self-compassion therapy, trauma-focused cognitive behavioral therapy (TF-CBT), and control groups from pretest to posttest. Table 1 presents the means and standard deviations for the subscales and total scores of self-criticism and resilience in the three study groups.

Table 1

Means and Standard Deviations of Self-Criticism and Resilience Scores at Pretest and Posttest Across the Three Groups

Variable	Stage	Self-Compassion Therapy M (SD)	TF-CBT M (SD)	Control M (SD)
Internalized self-criticism	Pretest	29.45 (2.34)	29.67 (2.41)	29.52 (2.28)
	Posttest	23.72 (2.18)	20.15 (1.94)	29.48 (2.31)
Comparative self-criticism	Pretest	28.38 (2.15)	28.52 (2.24)	28.43 (2.08)
	Posttest	22.56 (2.03)	18.27 (1.76)	28.39 (2.10)
Total self-criticism	Pretest	57.83 (2.98)	58.19 (2.87)	57.95 (2.92)
	Posttest	46.28 (2.57)	38.42 (2.23)	57.87 (2.89)
Personal competence and tenacity	Pretest	7.45 (1.23)	7.67 (1.34)	7.52 (1.28)
	Posttest	10.72 (1.42)	12.23 (1.67)	7.47 (1.25)
Trust in personal instincts and tolerance of negative affect	Pretest	8.38 (1.45)	8.52 (1.56)	8.43 (1.49)
	Posttest	11.53 (1.58)	18.13 (1.74)	8.39 (1.46)
Positive acceptance of change and secure relationships	Pretest	7.15 (1.32)	7.33 (1.41)	7.21 (1.35)
	Posttest	9.89 (1.47)	11.05 (1.63)	7.19 (1.33)
Control	Pretest	6.72 (1.18)	6.89 (1.27)	6.78 (1.22)
	Posttest	9.42 (1.35)	10.73 (1.52)	6.74 (1.20)
Spiritual influences	Pretest	8.56 (1.51)	8.74 (1.63)	8.63 (1.57)
	Posttest	11.92 (1.64)	13.36 (1.79)	8.59 (1.54)
Total resilience	Pretest	38.26 (2.34)	39.15 (2.48)	38.57 (2.41)
	Posttest	53.51 (2.89)	60.54 (13.36)	38.39 (2.38)

As shown in Table 1, the three groups had relatively similar mean scores at pretest, whereas substantial between-group differences emerged at posttest. Total self-criticism decreased from 57.83 to 46.28 in the self-compassion therapy group and from 58.19 to 38.42 in the TF-CBT group, corresponding to reductions of 11.55 and 19.77 points, respectively. In contrast, the control group demonstrated virtually no change, with the total self-criticism score decreasing only from 57.95 to 57.87. A similar pattern was observed for both internalized and comparative self-criticism, with the greatest reduction consistently occurring in the TF-CBT group. Regarding resilience, the total score increased from 38.26 to 53.51 in the self-compassion therapy group and from 39.15 to 60.54 in the TF-CBT group, whereas the control group showed essentially no improvement, changing from 38.57 to 38.39. The descriptive results therefore indicated that both interventions were associated with improvements in the expected directions, although the magnitude of change was consistently greater following TF-CBT.

Table 2

ANCOVA Results for Posttest Self-Criticism and Resilience Components After Controlling for Pretest Scores

Effect	Dependent Variable	SS	df	MS	F	p	Partial η^2
Pretest	Internalized self-criticism	42.36	1	42.36	28.24	< .001	.331
Pretest	Comparative self-criticism	38.75	1	38.75	25.83	< .001	.312
Group	Internalized self-criticism	58.42	2	29.21	19.47	< .001	.406
Group	Comparative self-criticism	53.18	2	26.59	17.73	< .001	.384
Pretest	Personal competence and tenacity	45.32	1	45.32	30.21	< .001	.346
Pretest	Trust in personal instincts and tolerance of negative affect	48.75	1	48.75	32.50	< .001	.363
Pretest	Positive acceptance of change and secure relationships	42.18	1	42.18	28.12	< .001	.330
Pretest	Control	39.64	1	39.64	26.43	< .001	.317
Pretest	Spiritual influences	51.27	1	51.27	34.18	< .001	.375
Group	Personal competence and tenacity	62.45	2	31.23	20.82	< .001	.422
Group	Trust in personal instincts and tolerance of negative affect	65.18	2	32.59	21.73	< .001	.433
Group	Positive acceptance of change and secure relationships	58.92	2	29.46	19.64	< .001	.408
Group	Control	55.37	2	27.69	18.46	< .001	.393
Group	Spiritual influences	68.54	2	34.27	22.85	< .001	.445

The multivariate analyses first demonstrated significant overall group differences for both outcome domains. For self-criticism, Pillai's trace was .463, $F(4, 110) = 12.35$, $p < .001$, partial $\eta^2 = .310$; Wilks' lambda was .542, $F(4, 108) = 11.82$, $p < .001$, partial $\eta^2 = .305$; Hotelling's trace was .845, $F(4, 106) = 13.12$, $p < .001$, partial $\eta^2 = .331$; and Roy's largest root was .726, $F(2, 55) = 14.28$, $p < .001$, partial $\eta^2 = .342$. For resilience, Pillai's trace was .624, $F(10, 106) = 16.32$, $p < .001$, partial $\eta^2 = .428$; Wilks' lambda was .485, $F(10, 104) = 14.89$, $p < .001$, partial $\eta^2 = .412$; Hotelling's

Before conducting the covariance analyses, the assumptions underlying multivariate and univariate analysis of covariance were examined. For self-criticism, Box's test was nonsignificant, Box's $M = 22.47$, $F = 1.12$, $p = .35$, indicating that the assumption of homogeneity of variance–covariance matrices was satisfied. Levene's tests were also nonsignificant for internalized self-criticism ($p = .40$) and comparative self-criticism ($p = .34$), supporting homogeneity of error variances across the three groups. Similarly, for resilience, Box's test was nonsignificant, Box's $M = 32.15$, $F = 1.24$, $p = .28$. Levene's tests were nonsignificant for personal competence and tenacity ($p = .41$), trust in personal instincts and tolerance of negative affect ($p = .33$), positive acceptance of change and secure relationships ($p = .39$), control ($p = .36$), and spiritual influences ($p = .42$). Thus, the assumptions of equality of variance–covariance matrices and homogeneity of variances were supported, permitting the use of MANCOVA followed by univariate ANCOVAs.

trace was 1.215, $F(10, 102) = 18.14$, $p < .001$, partial $\eta^2 = .467$; and Roy's largest root was .943, $F(5, 54) = 20.36$, $p < .001$, partial $\eta^2 = .485$. As presented in Table 2, after controlling for pretest scores, the group effect was statistically significant for internalized self-criticism, $F = 19.47$, $p < .001$, partial $\eta^2 = .406$, and comparative self-criticism, $F = 17.73$, $p < .001$, partial $\eta^2 = .384$. Thus, group membership accounted for approximately 38%–41% of the variance in posttest self-criticism scores. Significant group effects were likewise found for all resilience components,

including personal competence and tenacity, $F = 20.82$, $p < .001$, partial $\eta^2 = .422$; trust in personal instincts and tolerance of negative affect, $F = 21.73$, $p < .001$, partial $\eta^2 = .433$; positive acceptance of change and secure relationships, $F = 19.64$, $p < .001$, partial $\eta^2 = .408$; control, $F = 18.46$, $p < .001$, partial $\eta^2 = .393$; and spiritual influences, $F = 22.85$, $p < .001$, partial $\eta^2 = .445$. Accordingly, group membership explained approximately 39%–45% of the variance in the resilience components after adjustment for baseline scores, with the largest effect observed for spiritual influences.

Table 3

Bonferroni Post Hoc Comparisons of Adjusted Posttest Self-Criticism and Resilience Scores

Variable	Comparison	Mean Difference (I – J)	p
Internalized self-criticism	Self-compassion vs. TF-CBT	3.85	.004
	Self-compassion vs. Control	–5.95	< .001
	TF-CBT vs. Control	–9.80	< .001
Comparative self-criticism	Self-compassion vs. TF-CBT	3.45	.008
	Self-compassion vs. Control	–5.45	< .001
	TF-CBT vs. Control	–8.90	< .001
Personal competence and tenacity	Self-compassion vs. TF-CBT	–4.25	.003
	Self-compassion vs. Control	6.35	< .001
	TF-CBT vs. Control	10.60	< .001
Trust in personal instincts and tolerance of negative affect	Self-compassion vs. TF-CBT	–4.65	.002
	Self-compassion vs. Control	6.85	< .001
	TF-CBT vs. Control	11.50	< .001
Positive acceptance of change and secure relationships	Self-compassion vs. TF-CBT	–3.95	.005
	Self-compassion vs. Control	5.95	< .001
	TF-CBT vs. Control	9.90	< .001
Control	Self-compassion vs. TF-CBT	–3.75	.007
	Self-compassion vs. Control	5.65	< .001
	TF-CBT vs. Control	9.40	< .001
Spiritual influences	Self-compassion vs. TF-CBT	–4.85	.002
	Self-compassion vs. Control	7.05	< .001
	TF-CBT vs. Control	11.90	< .001

The Bonferroni-adjusted pairwise comparisons presented in Table 3 clarified the direction of the significant group effects. For self-criticism, both intervention groups demonstrated significantly lower adjusted posttest scores than the control group for internalized and comparative self-criticism (all $p < .001$). Moreover, the TF-CBT group had significantly lower internalized self-criticism than the self-compassion therapy group, with a mean difference of 3.85 points between the two treatment groups ($p = .004$), and significantly lower comparative self-criticism, with a mean difference of 3.45 points ($p = .008$). For resilience, both intervention groups demonstrated significantly higher adjusted posttest scores than the control group across all five components (all $p < .001$). Direct comparison of the two active interventions further showed that TF-CBT produced significantly greater improvement than self-compassion therapy in personal competence and tenacity ($MD = 4.25$, $p = .003$), trust in personal instincts and tolerance of negative affect ($MD = 4.65$, $p = .002$), positive acceptance of change and secure relationships ($MD = 3.95$, $p = .005$), control (MD

$= 3.75$, $p = .007$), and spiritual influences ($MD = 4.85$, $p = .002$). The largest difference between the two interventions was observed for spiritual influences. Taken together, these results indicate that although both self-compassion therapy and TF-CBT were effective in reducing self-criticism and enhancing resilience compared with the waiting-list condition, TF-CBT demonstrated consistently greater effectiveness across the measured outcomes.

4. Discussion and Conclusion

The present study compared the effectiveness of self-compassion therapy and trauma-focused cognitive behavioral therapy (TF-CBT) in reducing self-criticism and enhancing resilience among individuals with posttraumatic stress disorder (PTSD) related to the Iraqi Civil War. The findings demonstrated that both therapeutic interventions produced significant improvements compared with the waiting-list control condition. Specifically, participants who received either self-compassion therapy or TF-CBT showed significant reductions in internalized and comparative self-

criticism and significant increases across all assessed dimensions of resilience. The control group, in contrast, showed virtually no meaningful change between the pretest and posttest assessments. The covariance analyses confirmed that these differences remained significant after controlling for baseline scores, with relatively substantial effect sizes for both self-criticism and resilience. Furthermore, the Bonferroni comparisons indicated that TF-CBT was significantly more effective than self-compassion therapy in reducing both forms of self-criticism and in increasing all dimensions of resilience. Thus, although both interventions were therapeutically beneficial, the results supported a relative advantage for TF-CBT in addressing the psychological consequences examined in this war-related PTSD population.

The first major finding was that self-compassion therapy significantly reduced self-criticism among participants with war-related PTSD. This result is consistent with a growing body of evidence indicating that compassionate self-relating can weaken harsh, punitive, and negatively evaluative responses toward the self. Self-compassion involves treating personal suffering with kindness, recognizing distress as part of shared human experience, and maintaining balanced awareness of painful thoughts and emotions rather than responding with overidentification or self-condemnation (Neff, 2011, 2023). In people exposed to severe trauma, these processes may be particularly important because posttraumatic distress is frequently accompanied by guilt, shame, helplessness, and negative evaluations of one's behavior during or following traumatic events. By cultivating a supportive internal stance, self-compassion therapy may interrupt the cycle through which painful trauma-related memories trigger self-judgment and self-attack. The present finding is consistent with the systematic review and meta-analysis of Wakelin et al., which demonstrated that self-compassion-related interventions are effective in reducing self-criticism (Wakelin et al., 2022). It is also aligned with evidence that mindful self-compassion training can reduce self-criticism and shame (Ameri et al., 2025), and with findings demonstrating reductions in self-criticism following self-compassion-based interventions in other psychologically distressed populations (Hajrezaei & Hokmabadi, 2024).

The observed reduction in self-criticism can also be explained through the relationship between trauma, emotion regulation, and negative self-appraisal. PTSD is maintained not only by intrusive memories and physiological reactivity but also by the meanings individuals assign to the trauma

and to their own responses. When survivors interpret their fear, helplessness, avoidance, or emotional dysregulation as evidence of personal weakness, the trauma may become incorporated into a broader negative self-concept. Barlow et al. found that trauma appraisals, emotion-regulation difficulties, and self-compassion were important predictors of posttraumatic stress symptoms, suggesting that compassionate self-relating may buffer some of the cognitive-affective processes associated with PTSD (Barlow et al., 2017). Similarly, Crapolicchio et al. identified meaningful associations among self-criticism, self-acceptance, and PTSD in women exposed to interpersonal trauma, highlighting the role of self-directed evaluative processes in posttraumatic adjustment (Crapolicchio et al., 2021). Evidence from individuals with experiences of homelessness likewise suggests that self-compassion and self-criticism can function as mechanisms linking adverse experiences with posttraumatic symptoms (Igoe, 2024). Accordingly, self-compassion therapy may have reduced self-criticism in the present sample by changing how participants interpreted and emotionally responded to their suffering rather than merely attempting to suppress trauma-related thoughts.

The second important finding was that TF-CBT also produced a significant reduction in both internalized and comparative self-criticism and that its effect was significantly greater than that of self-compassion therapy. This result is theoretically plausible because trauma-focused cognitive behavioral approaches directly target maladaptive beliefs and cognitive distortions concerning the traumatic event, the self, other people, and future safety. War-related trauma may generate beliefs such as "I was weak," "I should have prevented what happened," "I cannot cope," or "my reactions mean that something is wrong with me." Such beliefs can intensify both internalized self-criticism, in which individuals judge themselves against rigid personal standards, and comparative self-criticism, in which they perceive themselves as less capable or less adequate than others. Through psychoeducation, cognitive restructuring, identification of automatic thoughts, trauma narrative work, emotion-regulation training, and gradual processing of trauma-related memories, TF-CBT can challenge these interpretations and promote more balanced evaluations of the self. This explanation is compatible with broader evidence showing the effectiveness of trauma-focused cognitive behavioral interventions for PTSD (Forbes et al., 2020) and with systematic evidence indicating that trauma-focused CBT can be beneficial even when individuals

remain exposed to ongoing or realistic threats (Ennis et al., 2021).

The superiority of TF-CBT in reducing self-criticism may reflect the more direct engagement of this intervention with the cognitive content of traumatic memories. Self-compassion therapy principally changes the manner in which individuals respond to suffering, whereas TF-CBT additionally challenges the specific maladaptive beliefs that sustain trauma-related guilt, shame, perceived incompetence, and danger. This interpretation is supported indirectly by studies demonstrating that cognitively oriented therapies can improve self-critical thinking. Solgi and Ghazi reported that cognitive-existential therapy reduced mental pain and self-criticism among women with PTSD symptoms (Solgi & Ghazi, 2022), while Gholizadeh found that schema therapy improved self-criticism and emotional self-regulation (Gholizadeh, 2022). Enhanced cognitive behavioral therapy has likewise been found to reduce self-criticism in adolescents experiencing body-image-related difficulties (Rahmani et al., 2025). Although these populations and protocols differ from those in the current study, they collectively suggest that interventions explicitly addressing dysfunctional cognitions can substantially modify self-critical processes. The present results extend this pattern to individuals with war-related PTSD by demonstrating that trauma-focused cognitive restructuring and processing may be particularly powerful in reducing negative self-evaluation.

The present study also showed that both interventions significantly enhanced resilience compared with the control condition. This finding is clinically important because resilience is not simply the absence of psychopathology; rather, it represents the capacity to adapt, maintain or regain functioning, and mobilize psychological resources when confronted with adversity. Contemporary resilience theory conceptualizes resilience as a dynamic process involving interactions among individual, relational, and contextual resources rather than as a fixed personal trait (Masten, 2018). In circumstances of war, forced migration, terrorism, and continuing insecurity, resilient adaptation can be particularly difficult because stressors are often cumulative and prolonged (Schwarzer, 2024). Nevertheless, evidence indicates substantial variability in psychological responses to war exposure, and resilience may protect against the development or persistence of PTSD (Fino et al., 2020). Therefore, the improvement in resilience observed in the current intervention groups suggests that both therapies may

have strengthened participants' adaptive resources rather than producing only symptom-focused change.

The effectiveness of self-compassion therapy in enhancing resilience is consistent with the view that compassionate self-regulation can facilitate adaptive coping under stressful conditions. Individuals who respond to themselves with kindness and balanced awareness may be less likely to become overwhelmed by shame, fear, or perceived failure and may instead recover more effectively following distress. Research has increasingly linked self-compassion with resilience across diverse populations. Clarke and Hartley found that self-compassion and mindfulness played supportive roles in resilience and mental health (Clarke & Hartley, 2025), while Weliangan et al. demonstrated an association between self-compassion and resilience among women managing multiple roles (Weliangan et al., 2024). Pank et al. similarly identified close relationships among self-care, self-compassion, resilience, and stress within psychological networks (Pank et al., 2025). Intervention evidence also supports this relationship, as compassion-based therapy has been found to improve resilience among individuals experiencing sustained caregiving demands (Rezavandi et al., 2025). These findings support the interpretation that self-compassion therapy in the present study may have increased resilience by reducing self-directed hostility, increasing emotional tolerance, strengthening acceptance of distress, and enabling participants to approach difficulties with greater perceived psychological resources.

Another mechanism that may account for the improvement in resilience is the reduction of rigid negative cognitive biases. War-related PTSD can involve persistent attention to threat, expectations of danger, reduced perceptions of personal competence, and pessimistic interpretations of future events. Resilience may counteract these processes by promoting flexible adaptation and more balanced cognitive responses. Wang et al. demonstrated that resilience has an important role in the relationship between earlier victimization and negative cognitive bias (Wang et al., 2023). In the context of war, resilience processes may similarly help individuals reinterpret adversity without allowing trauma to define their entire self-concept or future expectations. Research involving young people affected by the Ukraine–Russia war has highlighted the importance of building resilience through individual and interpersonal processes even while conflict-related stress remains present (Giordano et al., 2024). The substantial psychological burden documented among individuals living in conflict

settings further underscores the importance of interventions that build such adaptive capacities (Charlson et al., 2019; Morina et al., 2018; Tinsae et al., 2024).

The finding that TF-CBT produced significantly greater improvements in resilience than self-compassion therapy may be explained by the breadth of coping competencies addressed within the trauma-focused protocol. TF-CBT does not exclusively target symptoms or maladaptive thoughts; it also provides structured training in emotion identification, physiological relaxation, cognitive coping, trauma processing, personal safety, and management of trauma reminders. Successful engagement with traumatic memories may strengthen participants' perceived mastery and reduce the sense that trauma-related emotions are uncontrollable. In turn, this experience may contribute to greater personal competence, trust in one's ability to tolerate difficult affect, perceived control, and confidence when confronting future stress. Such mechanisms correspond closely to central dimensions of resilience. Evidence that trauma-focused treatments can reduce posttraumatic distress and facilitate adaptive emotional functioning supports this interpretation (Ennis et al., 2021; Forbes et al., 2020). Similarly, narrative exposure therapy has been shown to improve posttraumatic symptoms and related emotional outcomes among veterans with PTSD, illustrating the value of structured trauma processing in war-exposed populations (Khorsand Nobahar et al., 2023).

The relative advantage of TF-CBT may also be interpreted in light of the characteristics of war-related PTSD. War survivors often experience repeated and heterogeneous traumatic events rather than a single circumscribed trauma. These experiences may include witnessing death or injury, threats to personal survival, displacement, loss of loved ones, destruction of property, and persistent uncertainty. Studies of populations affected by armed conflict have repeatedly demonstrated high rates of PTSD and other psychiatric difficulties following war exposure (Carta et al., 2015; Hoppen & Morina, 2019; Priebe et al., 2010). More recent research has also demonstrated the impact of cumulative war-related stressors on both PTSD and complex PTSD symptoms (Lotzin et al., 2023). In this context, a treatment that directly organizes and processes trauma-related memories while modifying associated beliefs may have greater immediate effects on self-evaluation and coping capacity than an intervention whose primary mechanism is cultivating a compassionate relationship with the self. This interpretation does not diminish the therapeutic value of self-compassion; rather, it suggests that a trauma-

specific cognitive-behavioral framework may offer additional mechanisms especially relevant to complex war-related experiences.

It is also noteworthy that self-criticism and resilience are theoretically interconnected. Persistent self-criticism may consume psychological resources by maintaining shame, threat sensitivity, emotional avoidance, and perceived inadequacy, whereas greater resilience may involve the capacity to tolerate setbacks without escalating into global negative self-judgment. Longitudinal findings show dynamic relationships among self-criticism, self-compassion, psychological flexibility, and mental health, suggesting that these variables can influence one another across time (Wong et al., 2025). Meta-analytic evidence from other forms of psychopathology also indicates a consistent pattern in which greater self-criticism and lower self-compassion are associated with poorer psychological functioning (Paranjothy & Wade, 2024). Therefore, the simultaneous reduction in self-criticism and increase in resilience observed in the present study may represent related aspects of a broader recovery process: as participants became less punitive toward themselves and more capable of processing trauma-related emotions and cognitions, they may also have developed greater confidence in their ability to cope with adversity.

More broadly, the findings support current approaches that view PTSD treatment as involving changes in multiple psychological systems rather than symptom suppression alone. Advances in the field increasingly recognize the complex neurocognitive and affective mechanisms involved in PTSD, including threat-processing systems that are now being targeted through highly individualized interventions such as neurocircuitry-guided neuromodulation (van Rooij et al., 2026). However, accessible psychological therapies capable of modifying cognitions, emotion regulation, self-directed responses, and coping remain essential, particularly for large populations affected by war and displacement. The present findings suggest that both self-compassion therapy and TF-CBT can contribute to this broader recovery process. Self-compassion therapy appears to offer an effective route for reducing punitive self-relating and strengthening adaptive psychological resources, whereas TF-CBT may yield greater changes when trauma-specific beliefs, emotional responses, and coping patterns are directly processed. Taken together, the results suggest that both interventions are clinically useful for war-related PTSD, while providing comparative evidence in favor of TF-CBT for reducing self-criticism and enhancing resilience.

Several limitations should be considered when interpreting the findings. First, the sample was restricted to individuals with war-related PTSD who were accessible through a specific service setting, which may limit the generalizability of the findings to other war-affected populations, refugees, displaced individuals, military personnel, or survivors living in different cultural and socioeconomic circumstances. Second, the sample size was relatively limited, which may have reduced the precision of estimated treatment effects and the ability to investigate moderators such as age, sex, trauma severity, duration of PTSD, type of war exposure, or previous treatment history. Third, outcomes were assessed primarily through self-report instruments and may therefore have been influenced by recall bias, response tendencies, or participants' expectations regarding treatment. Fourth, the study used a waiting-list rather than an active control condition, meaning that nonspecific therapeutic factors such as therapist attention, group support, and treatment expectancy could not be fully separated from intervention-specific effects. Finally, the absence of longer-term follow-up assessments prevented evaluation of whether reductions in self-criticism and improvements in resilience were maintained after treatment termination.

Future studies should replicate these findings in larger and more heterogeneous samples drawn from multiple clinical centers and different war-affected communities. Including long-term follow-up assessments would clarify the stability of treatment gains and determine whether one intervention provides greater protection against subsequent symptom recurrence or exposure to new stressors. Researchers should also consider active control conditions and dismantling designs to distinguish specific treatment mechanisms from common therapeutic factors. Future investigations could examine mediating processes such as changes in trauma-related cognitions, shame, guilt, emotion regulation, experiential avoidance, psychological flexibility, self-compassion, and perceived self-efficacy to determine how each intervention produces improvement. Moderator analyses could identify which participants are most likely to benefit from self-compassion therapy or TF-CBT according to trauma characteristics, baseline self-criticism, resilience, symptom complexity, and sociodemographic factors. Comparative studies of sequential or integrated approaches would also be valuable, particularly interventions in which compassion-based skills are introduced before or alongside trauma-focused cognitive processing.

The findings support incorporating both self-compassion-based and trauma-focused cognitive behavioral interventions into psychological services for individuals experiencing war-related PTSD. Clinicians should routinely assess self-criticism and resilience in addition to core PTSD symptoms because these variables may influence recovery, treatment engagement, and long-term adjustment. Where severe trauma-related beliefs, avoidance, intrusive recollections, and perceived inability to cope are prominent, TF-CBT may be particularly suitable because it directly addresses trauma processing and cognitive restructuring while strengthening practical coping skills. Self-compassion therapy may be especially useful for individuals whose difficulties are characterized by pronounced shame, self-blame, harsh internal dialogue, and emotional intolerance. Mental health services in war-affected settings may also benefit from training clinicians in both approaches so that treatment can be tailored to individual psychological profiles and, when appropriate, elements of compassionate self-relating can be integrated with structured trauma-focused work.

Authors' Contributions

Authors equally contributed to this article.

Declaration

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

Transparency Statement

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All procedures performed in studies involving human participants were under the ethical standards of the institutional and, or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

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