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ORIGINAL RESEARCH

Alleviating the burden of depression: Exploring the efficacy of schema therapy for peer victimization, distress tolerance, and guilt in adolescence

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Abstract

Background and Objective: Depression during adolescence is a significant mental health concern, often associated with a range of negative outcomes, including peer victimization, difficulties with emotional regulation, and heightened feelings of guilt. This study investigated the effectiveness of schema therapy on peer victimization, distress tolerance, and guilt feelings in adolescents experiencing depressive symptoms.

Materials and Methods: Method: This study employed a quasi-experimental pre-test post-test control group design. The study population comprised adolescent boys residing in Ahvaz who presented with depressive symptoms during the year 2023. A convenience sample of 30 adolescents was recruited, and participants were then randomly assigned to either the experimental (n=15) or control (n=15) group. The experimental group received eight 90-minute sessions of schema therapy, administered weekly. The control group did not receive the schema therapy intervention. Data collection instruments included the Illinois Bully Scale (IBS), Distress Tolerance Scale (DTS), and Guilt Questionnaire. Analysis of covariance (ANCOVA) was conducted using SPSS version 27 to analyze the collected data.

Results: The results showed that schema therapy was effective in reducing peer victimization and feelings of guilt and increasing distress tolerance in adolescent boys with depressive symptoms ($P<0.001$).

Conclusion: This study concludes that schema therapy effectively reduces peer victimization and guilt while increasing distress tolerance in adolescent boys with depressive symptoms. These findings suggest schema therapy's potential as a valuable intervention for improving the social experiences, emotional regulation, and self-perception of depressed adolescents by targeting maladaptive schemas and fostering healthier coping mechanisms.

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Keywords: Depression, Schema therapy, Guilt, Victimization, Adolescent

Introduction

Depression is a pervasive mental health disorder with significant global impact on individuals and communities (1). Characterized by persistent sadness, anhedonia, and cognitive and emotional disturbances, it leads to fundamental impairments in individual, social, and academic functioning (2). Adolescents are particularly vulnerable to the onset of depressive symptoms due to the dynamic nature of their emotional and psychological development (3). Adolescence represents a sensitive developmental period during which individuals experience profound biological, cognitive, and social changes, predisposing them to mood disorders (4). In adolescents, depressive symptoms often manifest as irritability, anhedonia, social withdrawal, low self-esteem, and academic difficulties. These symptoms can further exacerbate maladaptive coping mechanisms and interpersonal conflicts, increasing the risk of adverse psychosocial outcomes (5).A significant contributing factor to depression in adolescents is peer victimization, defined as repeated exposure to bullying, harassment, or aggressive behaviors from peers (6). Peer victimization is strongly associated with increased depressive symptoms, eliciting feelings of helplessness, social rejection, and diminished self-esteem (7). Victimized adolescents frequently experience heightened stress responses, which can lead to emotional dysregulation and impaired coping abilities. Relatedly, distress tolerance—the capacity to withstand and manage negative emotional states—plays a critical role in determining an adolescent's vulnerability to depression (8). Low distress tolerance exacerbates the negative impact of peer victimization, as individuals with diminished emotional resilience are less equipped to mitigate the psychological harm resulting from repeated victimization experiences (9). Furthermore, adolescents with low distress tolerance are more prone to engaging in maladaptive behaviors, such as avoidance, substance use, or self-harm, thereby increasing their risk for depressive disorders (10). Distress tolerance is also closely related to guilt feelings, another significant factor in adolescent depression (11). Guilt, often defined as a negative emotional state arising from a perceived transgression or failure to meet moral or social standards, can manifest as both adaptive and maladaptive (12). While healthy guilt can motivate corrective actions, excessive or chronic guilt contributes to the development and maintenance of depressive symptoms (13). Adolescents with low distress tolerance may internalize negative experiences, such as peer victimization, leading to feelings of guilt and self-blame. This maladaptive guilt can reinforce depressive cognitions and create a cycle of emotional distress that exacerbates both psychological suffering and functional impairment (14). Studies have demonstrated that adolescents exhibiting high levels of guilt are at increased risk for self-destructive behaviors, as the emotional burden of guilt often becomes overwhelming, leading to further emotional dysregulation and the perpetuation of depressive symptoms (15). Moreover, unresolved guilt can negatively impact social relationships, fostering feelings of isolation and alienation, which further contributes to depressive experiences (16). Given the complex interplay between peer victimization, distress tolerance, guilt, and depression, effective interventions are essential to address these interconnected psychological issues. While traditional therapeutic approaches, such as cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT), have been widely used to treat adolescent depression (17, 18), emerging evidence suggests that schema therapy may offer additional benefits by addressing the underlying cognitive and emotional schemas that contribute to these difficulties (19). Schema therapy is an integrative approach that combines cognitive, behavioral, and experiential techniques to modify deeply ingrained maladaptive schemas developed from early life experiences (20). By targeting dysfunctional cognitive and emotional patterns, schema therapy facilitates the development of healthier coping strategies and improved emotional resilience (21). Within the context of adolescent depression, schema therapy has demonstrated effectiveness in reducing depressive symptoms (22, 23), increasing distress tolerance (24), and addressing maladaptive guilt (25, 26). Moreover, schema therapy provides adolescents with strategies to reframe and process experiences of peer victimization, ultimately fostering a stronger sense of self-worth and improved emotional regulation (20). Therefore, by addressing core

schemas that underlie distress and maladaptive coping mechanisms, schema therapy offers a promising intervention for mitigating the impact of peer victimization, low distress tolerance, and excessive guilt in adolescents presenting with depressive symptoms. This study investigates the effectiveness of schema therapy in reducing these associated psychological challenges in adolescent boys, thereby contributing to a more comprehensive understanding of therapeutic interventions for adolescent depression. Furthermore, the findings may provide valuable insights for practitioners, educators, and policymakers in developing more effective mental health interventions tailored to the unique psychological needs of adolescents experiencing depression and its associated psychosocial challenges. Thus, this study aimed to determine the effectiveness of schema therapy on peer victimization, distress tolerance, and guilt feelings in adolescent boys with depressive symptoms.

Materials and Methods

Design and participants

Method: This study employed a quasi-experimental pre-test and post-test control group design. The study population consisted of adolescent boys residing in Ahvaz who presented with depressive symptoms during the year 2023. A convenience sample of 30 adolescents was recruited, and participants were subsequently assigned to either the experimental (n=15) or control (n=15) group. Inclusion criteria were: age between 15 and 18 years; diagnosis of depressive symptoms, evidenced by a score above the mean on the Beck Depression Inventory; and provision of informed consent to participate. Exclusion criteria included unwillingness to cooperate with the researcher and absence from more than two intervention sessions.

Measure

The Illinois Bully Scale (IBS): In the present study, to measure peer victimization, we used the Illinois Bully Scale designed in 2001 (27). This scale has 18 items and three subscales called bullying, fighting, and victimization. To score this questionnaire, first, in each phrase, give a score in the following order: Never: score 1; Rarely: score 2; Sometimes: score 3; Most of the time: score 4; Always: score 5. The lower limit of scores in this questionnaire is 18, the middle limit is 45 and the upper limit is 90. In the research (28), the reliability of the scale was obtained from Cronbach's alpha method above 0.70. The calculated reliability in the present study for this scale is 0.71.

The Distress Tolerance Scale (DTS): The DTS, a 15-item self-report measure developed by Simons and Gaher (29), assesses an individual's capacity to tolerate distress. The DTS is comprised of four subscales: Tolerance of Distressing Emotions, Absorption in Negative Emotions, Appraisal of Capacity and Distress Experienced, and Regulation of Emotions. Participants respond to items using a five-point Likert scale ranging from "totally agree" to "totally disagree" (1-5), yielding a total score ranging from 15 to 75. Higher scores on the DTS reflect greater distress tolerance. In terms of reliability, the DTS has demonstrated acceptable internal consistency, with a reported Cronbach's alpha coefficient of 0.77 (30).

The Guilt Questionnaire: The Guilt Questionnaire is a self-report instrument designed to assess guilt. Developed, completed, and revised by Jones et al. (31), the questionnaire comprises 45 items across three subscales: Guilt Trait, Guilt States, and Moral Standards. Items are rated on a five-point Likert scale (1 to 5), yielding a total score ranging from 45 to 225, with a midpoint of 135. Shahmiri et al. (32) reported a Cronbach's alpha of 0.74 for this instrument. In the present study, the calculated reliability (Cronbach's alpha) for the Guilt Questionnaire was 0.78.

Procedure

Following ethical approval from the university, secondary schools in Ahvaz were contacted, and after explaining the study objectives and with the schema therapist present, permission was obtained to conduct the research within these schools. From the adolescent population, 30 participants who met the criteria for depression, as determined by the Beck Depression Inventory, were selected via convenience sampling and subsequently assigned to either the experimental or control group. Prior to the intervention, all participants completed pre-tests assessing peer victimization, distress tolerance, and guilt. The experimental group then received schema

therapy intervention over a two-month period, consisting of eight weekly 90-minute sessions. The control group did not receive the intervention. A summary of the schema therapy sessions is provided in Table 1. Following the intervention period, all participants completed post-tests assessing peer victimization, distress tolerance, and guilt.

Table 1. A summary of the schema therapy sessions

Session	Content
1	Introduction to therapy, establishing a therapeutic relationship, explaining schema concepts, examining early experiences of victimization and guilt.
2	Identifying early maladaptive schemas, exploring the relationship between schemas and depression, victimization, and distress tolerance.
3	Focusing on victimization-related schemas, examining the role of early memories in the formation of these schemas.
4	Techniques for changing maladaptive beliefs, introducing healthy coping strategies for distress tolerance.
5	Identifying maladaptive guilt, examining the role of self-blaming thoughts in the continuation of depression.
6	Using experiential techniques for emotional change, confronting painful feelings caused by victimization.
7	Developing behavioral and cognitive strategies to manage guilt and increase distress tolerance.
8	Reviewing and integrating learning, planning to maintain positive changes and prevent relapse into unhealthy patterns.

Data Analysis

Descriptive statistics included mean and standard deviation, and inferential statistics included univariate and analysis of covariance (ANCOVA). SPSS version 27 software was used to analyze the data.

Results

The study participants comprised 30 adolescents, aged 15 to 18, who presented with depressive symptoms. The mean ages for the experimental and control groups were 16.82±1.46 and 17.25±1.72, respectively. Means and standard deviations for peer victimization, distress tolerance, and guilt, as measured at pre-test and post-test, are presented in Table 2. Results indicated a decrease in peer victimization and guilt scores from pre-test to post-test within the experimental group, a change not observed in the control group. Furthermore, the experimental group demonstrated a significant increase in distress tolerance scores at post-test, whereas the control group showed no such change.

Table 2. Mean and standard deviation (SD) of research variables

Variable	Phase	Schema therapy group		Control group	
		Mean	SD	Mean	SD
Peer victimization	Pre-test	52.46	5.21	53.20	4.89
	Post-test	44.53	4.80	53.46	5.38
Guilt	Pre-test	37.13	3.16	37.06	3.75
	Post-test	44.60	4.99	36.33	5.12
Distress tolerance	Pre-test	146.89	9.96	147.06	8.64
	Post-test	133.06	8.21	146.42	9.18

The Kolmogorov-Smirnov test confirmed the normal distribution of peer victimization, guilt, and distress tolerance scores within both the experimental and control groups. Homogeneity of variance was further established using Levene's test. Results from the ANCOVA examining post-test scores for peer victimization, guilt, and distress tolerance across the experimental and control groups are presented in Table 3

Table 3. Results of ANCOVA on post-test scores of peer victimization, guilt, and distress tolerance

Variables	SS	df	MS	F	P	η'
Peer victimization	555.49	1	555.49	108.95	0.001	0.79
Guilt	489.14	1	489.14	141.21	0.001	0.84
Distress tolerance	1256.42	1	1256.42	152.40	0.001	0.89

As shown in Table 3, after controlling for pre-test scores, statistically significant differences emerged between the experimental and control groups for peer victimization ($F=108.95$, $P<0.001$), distress tolerance ($F=141.21$, $P<0.001$), and guilt ($F=152.40$, $P<0.001$). Specifically, in comparison to the control group, the experimental group demonstrated a statistically significant decrease in peer victimization and guilt scores, and a statistically significant increase in distress tolerance scores. These results indicate that the schema therapy intervention was effective in reducing peer victimization and guilt, and in increasing distress tolerance, among adolescents with depressive symptoms.

Discussion

This study investigated the efficacy of schema therapy in influencing peer victimization, distress tolerance, and guilt in adolescent boys experiencing depressive symptoms. The findings indicated that schema therapy resulted in a significant decrease in peer victimization and guilt scores, and a significant increase in distress tolerance, among adolescents with depressive symptoms. Thus, schema therapy proved effective in reducing peer victimization and guilt, and in enhancing distress tolerance. These results align with previous research, including studies by Kopf-Beck et al. (22), Fereydooni and Sheykhan (23), and Ghassemi Koushikolaei et al. (26).

Schema therapy is predicated on the principle that early maladaptive schemas, developed as a result of unmet childhood emotional needs, influence adolescent thoughts, feelings, and behaviors (33). Peer victimization, characterized by repeated exposure to bullying,

rejection, or peer aggression, can reinforce and activate these maladaptive schemas, particularly those related to abandonment, mistrust, defectiveness, and social isolation (34). Adolescents experiencing depression often exhibit heightened cognitive and emotional sensitivity to peer rejection, which perpetuates negative self-perceptions and maladaptive coping mechanisms (6).

The mechanism through which schema therapy addresses peer victimization in depressed adolescents involves modifying deeply ingrained schemas and associated coping styles through cognitive, experiential, and behavioral interventions. Cognitive techniques challenge and restructure maladaptive beliefs regarding self-worth and social expectations, enabling adolescents to develop more adaptive interpretations of peer interactions (19). Experiential techniques, such as imagery rescripting and chair work, facilitate the emotional processing and reconstruction of distressing memories related to victimization, thereby reducing the emotional intensity associated with past experiences. Behavioral interventions promote healthier coping strategies and assertive social behaviors, replacing maladaptive responses like avoidance, surrender, or aggression. The therapeutic relationship provides a corrective emotional experience, assisting adolescents in internalizing healthier communication patterns and fostering trust in social interactions. Ultimately, schema therapy promotes emotional regulation, self-compassion, and resilience, mitigating the negative impact of peer victimization on depressive symptoms.

Cognitive techniques employed in schema therapy sessions focus on identifying and challenging maladaptive schemas and their associated automatic thoughts (20). Adolescents who have experienced peer victimization often hold core beliefs of defectiveness, unlovability, or mistrust, which contribute to cognitive distortions such as catastrophizing, overgeneralization, and personalization. Cognitive restructuring facilitated the identification and modification of these distorted thoughts by prompting adolescents to examine supporting and refuting evidence, thereby fostering more balanced perspectives on peer interactions. Schema dialogues, in which adolescents contrast the perspectives of different schema modes (e.g., vulnerable child versus healthy adult), further supported cognitive change (22). Experiential techniques aim to process and transform emotionally charged memories related to victimization. Imagery rescripting, a key technique, involved the therapist guiding adolescents through visualizations of past distressing events and modifying the narrative to provide a corrective emotional experience. This process allowed adolescents to reframe traumatic memories by incorporating elements of safety, protection, and empowerment, ultimately reducing the emotional intensity of the schema. Chair work, another experiential technique used in this study, facilitated direct interaction with internalized, schema-driven voices, such as self-criticism or punitiveness, through role-playing. This technique encourages self-compassion and strengthens the healthy adult mode, promoting resilience and a more adaptive self-perception.

Schema therapy has the potential to significantly reduce excessive or maladaptive guilt in depressed adolescents who have experienced peer victimization by targeting underlying maladaptive schemas and ineffective coping strategies that reinforce self-blame (35). In this population, guilt often originates from schemas such as defectiveness/shame, self-sacrifice, and criticism, which predispose adolescents to internalize responsibility for negative social experiences, even when they are not at fault. Peer victimization can exacerbate these maladaptive beliefs, leading adolescents to feel undeserving of support or to believe they somehow provoked the mistreatment (36).

As with the other variables, cognitive restructuring was employed to address guilt. Within the framework of schema therapy, this technique assisted adolescents in identifying and challenging distorted guilt-related cognitions. Many victimized adolescents demonstrated excessive self-blame stemming from cognitive distortions such as personalization (assuming responsibility for others' negative actions) and mind-reading (believing others inherently view them as flawed) (7). By examining evidence contradicting these irrational beliefs and

developing more balanced perspectives, adolescents learned to differentiate their actual responsibility from feelings of guilt and to reduce self-blame. Experiential techniques, particularly imagery rescripting, directly targeted the emotional charge of guilt-laden memories. In guided imagery exercises, adolescents revisited past experiences of peer victimization and modified the narrative by incorporating self-compassion, external support, and more accurate attributions of responsibility. For instance, rather than reinforcing the belief that they deserved mistreatment, some adolescents in this study visualized intervening or establishing boundaries, which contributed to the attenuation of ingrained guilt and the enhancement of self-worth. Chair work further facilitated emotional processing, enabling adolescents to engage in dialogue between their internalized punitive or self-critical schema modes and their healthy adult mode, thereby promoting self-forgiveness and emotional healing (20).

Furthermore, schema therapy can enhance distress tolerance in depressed adolescents who have experienced peer victimization by targeting maladaptive schemas and ineffective coping mechanisms that contribute to diminished emotional resilience. Adolescents with a history of peer victimization frequently demonstrate low distress tolerance due to heightened sensitivity to social rejection, negative self-perception, and maladaptive coping strategies, such as avoidance, withdrawal, or self-criticism (37). Through cognitive restructuring, schema therapy assists adolescents in reframing distressing experiences and challenging catastrophic interpretations of peer interactions. By mitigating cognitive distortions, such as overgeneralization and personalization, adolescents learn to perceive uncomfortable social situations in a more balanced and less threatening manner. This cognitive shift strengthens distress tolerance by reducing emotional reactivity and promoting adaptive coping strategies (38).

In this study, the therapist, utilizing experiential techniques, particularly imagery rescripting, played a crucial role in modifying the emotional intensity of past victimization experiences. By revisiting distressing memories within a safe therapeutic environment and altering the narrative to incorporate protection and empowerment, adolescents developed greater emotional resilience. This process diminished avoidance tendencies and increased the capacity to tolerate uncomfortable feelings rather than being overwhelmed by them. Chair work facilitated enhanced distress tolerance by enabling adolescents to confront internalized punitive or self-critical voices, fostering self-compassion and emotional self-regulation (24). Behavioral interventions promoted increased distress tolerance by encouraging engagement with challenging social situations in a structured and supportive manner. Exposure exercises assisted adolescents in confronting anxiety-provoking social scenarios, gradually reducing anxiety and building confidence in their ability to manage discomfort. Behavioral experiments, focusing on assertive communication and social risk-taking, provided opportunities for adolescents to practice distress tolerance in real-world interactions, reinforcing the belief that they can navigate peer relationships without succumbing to emotional distress.

Regarding limitations, the present study's focus on a sample of boys residing solely in Ahvaz may limit the generalizability of the findings. The study's reliance on self-report measures for peer victimization, distress tolerance, and guilt introduces the potential for response bias, which could affect the accuracy of the results and the perceived treatment effectiveness. Finally, the absence of a follow-up period precludes an assessment of the long-term effectiveness of schema therapy.

Conclusion

In conclusion, this study's findings support the efficacy of schema therapy in addressing key challenges faced by adolescent boys experiencing depressive symptoms. Results demonstrate that schema therapy significantly reduced both peer victimization and feelings of guilt, while simultaneously increasing distress tolerance within this population. These improvements suggest that schema therapy may offer a valuable intervention for mitigating the negative impact of depression on adolescents' social experiences, emotional regulation, and self-perception. The reduction in peer victimization may be attributed to schema therapy's focus on challenging maladaptive schemas that contribute to social difficulties and empowering adolescents to develop more

assertive and adaptive interpersonal strategies. Furthermore, the observed decrease in guilt feelings and increase in distress tolerance likely reflect schema therapy's emphasis on addressing core emotional needs, fostering self-compassion, and building healthier coping mechanisms. These findings contribute to the growing body of evidence supporting the use of schema therapy with adolescents and highlight its potential to improve psychosocial functioning and well-being in young people struggling with depression. Future research could explore the specific mechanisms through which schema therapy exerts these effects and investigate its long-term impact on this population. Additionally, comparing schema therapy to other evidence-based interventions for adolescent depression would further inform clinical practice and guide treatment recommendations.

Ethical approval

This research was carried out in compliance with the ethical standards established by the Ethical Committee of Islamic Azad University, Ahvaz Branch, under approval code IR.IAU.AHVAZ.REC.1403.211.

Conflict of interest

The authors declare no conflict of interest.

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