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Comparison of the Effectiveness of Short-Term Solution-Focused Therapy and Compassion-Focused Therapy on Self-Efficacy in Married Women

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ABSTRACT

The present study was conducted to compare the effectiveness of short-term solution-focused therapy and compassion-focused therapy on self-efficacy in married women. The research method was experimental, using a pretest-posttest-follow-up design with a control group. The statistical population consisted of all married women who referred to the Hazrat Zainab Cultural Center in Mashhad during the 2022–2023 academic year. The sample included 60 women selected through convenience sampling and randomly assigned to three groups of 20 participants each. The instrument used in this study was the General Self-Efficacy Questionnaire by Sherer et al. (1982). The short-term solution-focused therapy was conducted in six 90-minute sessions using the Diamond model, while the compassion-focused therapy sessions followed Gilbert's (2014) protocol and included twelve 90-minute sessions held weekly. The control group was placed on a waiting list. A pretest was administered before the intervention, a posttest after the sessions, and a follow-up assessment was conducted two months later. During the course of the intervention and assessments, two participants from both the control group and the solution-focused therapy group dropped out, along with four participants from the compassion-focused therapy group. The data were analyzed using SPSS-27 software and repeated measures analysis of variance (ANOVA). The findings revealed that in the posttest and follow-up phases, there were statistically significant differences between the experimental groups (compassion-focused therapy and solution-focused therapy) and the control group. The results indicated that both therapeutic approaches were effective in enhancing self-efficacy in married women and had lasting effects ($p < .05$); however, there was no significant difference in the effectiveness between the two approaches.

Keywords: Self-efficacy, short-term solution-focused therapy, compassion-focused therapy, married women.

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Introduction

In contemporary psychological research and therapeutic practice, enhancing self-efficacy in women—particularly within the marital context—has gained increasing attention due to its vital role in psychological well-being, relationship satisfaction, and adaptive functioning. Self-efficacy, as conceptualized by Bandura, refers to individuals' belief in their capacity to execute behaviors necessary to produce specific performance attainments. It significantly influences emotional resilience, motivation, and interpersonal dynamics, especially in women navigating the complex demands of marital life. Recent studies highlight that marital dissatisfaction, psychological distress, and internalized self-criticism often correlate with diminished self-efficacy in married women, necessitating therapeutic interventions tailored to strengthen their internal coping mechanisms and self-beliefs (1, 2).

Among the diverse therapeutic approaches evaluated for their impact on self-efficacy, Compassion-Focused Therapy (CFT) and Solution-Focused Brief Therapy (SFBT) have emerged as particularly relevant and empirically supported. CFT, developed by Paul Gilbert, is rooted in evolutionary psychology and compassion-based practices and emphasizes self-kindness, emotional regulation, and affiliative motivation to counteract shame, self-criticism, and fear of compassion. It has demonstrated effectiveness in enhancing psychological resilience and emotional well-being, particularly among women experiencing internalized negative emotions or relational trauma (3, 4). In comparison, SFBT is a future-oriented, goal-directed model emphasizing clients' strengths and resources, rather than pathology or deficits. It is brief, collaborative, and particularly suited for improving self-efficacy by helping individuals visualize and enact solutions rather than ruminate on problems (5, 6).

Evidence suggests that both therapeutic frameworks are highly applicable to populations of married women. Studies have shown that self-compassion not only moderates the impact of emotional stress but also buffers against self-criticism and maladaptive rumination, contributing to enhanced marital functioning and emotional self-regulation (2, 7). Compassion-based interventions have effectively increased resilience and reduced psychological distress in diverse female populations, including elderly women post-COVID and survivors of domestic violence (8, 9). Meanwhile, solution-focused therapy has proven effective in increasing self-efficacy and marital satisfaction among married women, particularly when delivered in group formats or adapted for culturally specific populations (10, 11).

The application of CFT in marital contexts reveals promising outcomes. For instance, Davarnia et al. (2019) found that CFT significantly reduced rumination in women affected by marital infidelity, indicating the therapy's capacity to rebuild a sense of emotional agency and self-trust (12). Similarly, Asadi Bijaeyeh et al. (2021) demonstrated that self-compassion training enhanced both life satisfaction and resilience among elderly women, reinforcing the broader utility of compassion-based interventions beyond strictly clinical populations (13). Moreover, Nasir-Herand et al. (2024) compared CFT and schema therapy and concluded that CFT was highly effective in improving self-efficacy and reducing rumination in married female students, thereby affirming its relevance for married women experiencing cognitive-emotional dysregulation (3).

SFBT has likewise been widely endorsed in the literature as an efficient method for cultivating self-efficacy. Its emphasis on brief, solution-oriented dialogue aligns well with the time constraints and practical concerns of adult women, especially those managing household and caregiving responsibilities. Bagheri et al. (2024) reported significant improvements in self-efficacy beliefs among female students with social

anxiety disorder following SFBT, demonstrating the therapy's efficacy across diagnostic groups (14). Similarly, Turns et al. (2019) observed that SFBT improved psychological outcomes among couples raising children with autism, emphasizing the therapy's adaptability to high-stress relational environments (15).

Beyond clinical measures, SFBT has also shown considerable utility in educational and personal development contexts. Jenkins and Germaine (2023) presented a solution-oriented learning model that promoted motivation and resilience, drawing parallels between academic and therapeutic applications of solution-focused thinking (6). In the Iranian context, CFT and SFBT have been adapted to suit cultural and familial norms, which is particularly important when working with married women whose psychological health is often shaped by relational expectations and collective identity frameworks (11, 16).

Additionally, the cognitive-emotional mechanisms underpinning these therapies offer complementary routes to enhancing self-efficacy. CFT promotes emotional regulation and affiliative emotion systems through compassion-based mindfulness, enabling clients to shift from self-judgment to self-soothing responses during stress (4, 17). SFBT, by contrast, employs structured questioning techniques such as the miracle question and scaling to shift attention from problems to possible solutions, encouraging clients to articulate and actualize personal successes (5, 18). Both approaches cultivate internal agency and self-reflection but do so through different epistemological frameworks—CFT through emotional and evolutionary theory, and SFBT through constructivist and narrative practice.

It is also critical to consider the psychological constructs that moderate the effectiveness of these interventions. Self-silencing, attachment insecurity, and emotional expressiveness have been identified as key mediators in the relationship between self-compassion and psychological adjustment in married women (7). Furthermore, Kim et al. (2017) in a multilevel meta-analysis found that SFBT yields moderate to large effect sizes across a range of psychosocial outcomes, reinforcing the model's empirical robustness (19). This further substantiates the rationale for selecting SFBT as a comparative intervention alongside CFT in the present study.

The importance of addressing self-efficacy in married women cannot be overstated. As shown by Alizadeh et al. (2024), self-compassion significantly predicts marital adjustment, underscoring its central role in relational harmony and personal empowerment (1). Moreover, Taghavi et al. (2020) found that both SFBT and Acceptance and Commitment Therapy (ACT) effectively enhanced quality of life and self-efficacy among housewives, yet SFBT had the advantage of being shorter in duration and more accessible (20). These findings suggest that both compassion and solution-focused approaches are aligned with the therapeutic needs of married women, especially in settings where long-term psychotherapy may not be feasible.

Despite the growing body of literature, comparative studies evaluating the relative effectiveness of CFT and SFBT on self-efficacy in married women remain limited. While both therapies have independently demonstrated promising results, head-to-head comparisons that assess their differential impacts on sustained self-efficacy enhancement are scarce. This gap justifies the necessity of the present study, which seeks to empirically examine and compare the effectiveness of compassion-focused therapy and short-term solution-focused therapy in enhancing self-efficacy among married women in a structured intervention model.

Methods and Materials

Study Design and Participants

This study is applied in nature and employed an experimental method using a pretest-posttest design with a two-month follow-up and a control group. The statistical population included all married women who visited the Hazrat Zainab Cultural Center during the 2022–2023 academic year. After initial registration, individuals meeting the inclusion and exclusion criteria were enrolled in the study. Inclusion criteria were: having at least a high school diploma, not receiving concurrent psychological treatment, being married, having been married for more than one year, and willingness to participate in the study.

Exclusion criteria included absence from more than two sessions, separation from spouse, and lack of consent to participate in the research.

From among the married women who visited the Hazrat Zainab Cultural Center during the 2022–2023 period, 60 participants were selected. Twenty participants were randomly assigned to each of the three research groups. It is worth noting that two participants dropped out from the control group, two from the short-term solution-focused therapy group, and four from the compassion-focused therapy group during different evaluation phases. Thus, the control group was reduced to 18 participants, the short-term solution-focused therapy group to 18, and the compassion-focused therapy group to 16 participants.

After obtaining all necessary approvals from the university and coordinating with the Hazrat Zainab Cultural Center, participants were recruited through a public call. All participants completed the self-efficacy questionnaire before and after the intervention sessions. The researcher committed to ethical standards and agreed to offer the intervention to the control group after the study concluded. The compassion-focused therapy was administered in twelve 90-minute sessions, and the short-term solution-focused therapy was conducted in six 90-minute sessions over a two-month period. A follow-up assessment was conducted two months after the conclusion of the interventions.

Data Collection

General Self-Efficacy Scale (GSES): The General Self-Efficacy Questionnaire was developed by Sherer et al. (1982) to assess beliefs about self-efficacy. It consists of 23 items, with 17 items measuring general self-efficacy and 6 items related to self-efficacy experiences in social situations. The total score ranges from 17 to 85 and is rated on a 5-point Likert scale. Items 1, 3, 8, 9, 13, and 15 are reverse scored from 5 to 1, and the rest are scored from 1 to 5. The maximum possible score is 85, and the minimum is 17. Sherer et al. (1982) reported a Cronbach's alpha reliability coefficient of .86 for the general self-efficacy subscale. The questionnaire was standardized in Iran by Asgharnejad et al. (2006), who translated and validated the instrument and confirmed its reliability and validity. In their study, the Cronbach's alpha was estimated at .76. In the present study, internal consistency reliability was calculated using Cronbach's alpha and found to be .77.

Intervention

The compassion-focused therapy protocol used in this study consisted of twelve structured 90-minute weekly sessions. The intervention began with an introduction to the principles of CFT and basic mindfulness

training, helping participants become more aware of their thoughts and emotions through breathing-focused exercises. The second session delved into the three emotion regulation systems—threat, drive, and soothing—and participants learned to identify triggers of the threat system in their daily experiences. In the third session, self-compassion was introduced through safe-place imagery and writing compassionate letters to oneself, while the fourth session deepened this practice by exploring internal barriers such as shame and guilt, using visualization of a compassionate self. Session five focused on accepting and managing negative emotions without suppression, integrating soothing rhythm breathing. The sixth session aimed to advance emotion regulation through compassion flow imagery and applying it in real-life emotional challenges. Cognitive restructuring was introduced in the seventh session through compassionate reframing of self-critical thoughts. In session eight, self-acceptance was reinforced through compassionate self-talk and addressing deeper barriers such as trauma or chronic shame. The ninth session expanded the compassion practice outward, encouraging participants to cultivate compassion toward others, especially their spouses, while session ten emphasized compassion-based communication skills through role-playing and active listening techniques. Session eleven consolidated core skills by revisiting mindfulness and compassion exercises, integrating them into real-life problem-solving scenarios. Finally, session twelve focused on reviewing progress, offering peer feedback, and helping participants design a personalized plan to sustain their compassion practices in daily life over the next month.

The SFBT intervention was conducted over six 90-minute sessions using the culturally adapted Diamond Model. The first session introduced the group process and included culturally inspired ice-breakers to establish rapport, followed by conceptual teaching on self-efficacy, emotional regulation, and marital adjustment. Participants defined individual goals for the group. As homework, they were asked to list things in their marital or personal life that were going well and did not need changing. In the second session, participants envisioned a preferred future regarding each target variable using scaling questions (from 0 to 10), reflected on past positive actions, and shared empathic feedback with the group. They were then instructed to document five signs of improvement observed during the week. Session three explored changes since the last session, helping participants recognize their own role in progress and appreciate the impact of their personal strengths. The homework involved describing a recent emotional or relational improvement and its effects. In the fourth session, participants recalled and analyzed past successes in managing emotions or relational issues, identifying contextual factors and helpful strategies. They were asked to write about two or three past successful experiences and extract lessons from them. The fifth session focused on identifying obstacles and coping strategies, mapping out supportive relationships, and encouraging reuse of internal and external resources. Participants listed traits or people that had previously supported their self-efficacy or relationship quality. Finally, the sixth session reviewed individual progress using the scaling method, developed action plans to maintain changes, introduced ways to celebrate progress, and helped participants design a future-oriented plan with goals, support systems, and motivation-sustaining strategies.Data Analysis

After the completion of the intervention sessions, posttests were administered to all three groups. The collected data were analyzed using SPSS version 27, employing descriptive statistics (mean and standard deviation) and repeated measures analysis of variance (ANOVA).

Findings and Results

In this study, the demographic characteristics of the sample were described using descriptive statistics, including frequency, percentage, mean, and standard deviation. The mean age of participants in the compassion-focused therapy group, solution-focused therapy group, and control group was 39.95, 40.30, and 39.25 years, respectively. One-way ANOVA revealed no significant differences in age between the groups ($p = .909$). Regarding employment status, 66.7% of the women were housewives, and 33.3% were employed. In terms of education level, 78.3% held a high school diploma, and 21.7% had a bachelor's degree. The distribution of demographic variables was relatively equal across the three research groups.

Table 3 presents the means and standard deviations of self-efficacy scores across three evaluation phases for the three groups.

Table 1. Mean and Standard Deviation of Total Self-Efficacy Scores of Women by Study Groups (Pretest, Posttest, and Follow-Up)

Assessment Phase	Compassion-Focused Therapy	Solution-Focused Therapy	Control Group	Total
Pretest	55.00 (15.79)	51.56 (9.16)	51.83 (4.19)	52.71 (11.47)
Posttest	63.25 (13.81)	63.94 (7.94)	52.28 (3.71)	59.69 (10.55)
Follow-Up	64.50 (14.48)	64.78 (7.67)	52.61 (3.88)	60.48 (10.94)

Table 1 shows the mean and standard deviation of women's self-efficacy scores by study group at pretest, posttest, and follow-up. To examine mean differences among the three groups and across the three evaluation stages, repeated measures ANOVA was employed. Prior to conducting the ANOVA, assumptions were tested as follows:

A. Normality of data distribution: Using the Shapiro–Wilk test, the assumption of normality was checked. The results showed that most variables were normally distributed; however, normality was not confirmed for the compassion-focused therapy group in the posttest and follow-up. Therefore, rank transformation was used for normalization.

B. Homogeneity of variances: One-way ANOVA on pretest self-efficacy scores showed no significant differences between groups, indicating homogeneity. Levene's test also revealed no significant results, confirming equality of variances across groups.

C. Equality of covariance matrices: M-Box test results confirmed the assumption of equality of covariance matrices for all three variables.

D. Sphericity: Mauchly's test indicated a violation of the sphericity assumption. As a result, Greenhouse-Geisser correction was applied to adjust the degrees of freedom.

Research Hypothesis

There is a difference in the effectiveness of compassion-focused therapy and solution-focused therapy on self-efficacy in married women.

Table 2 presents the results of the repeated measures ANOVA (with corrected degrees of freedom) examining the main effects of group and time, and the interaction effect of time and group on self-efficacy.

Table 2. Results of Repeated Measures ANOVA for Main and Interaction Effects on Self-Efficacy in Married Women

Source of Variation	SS	df	MS	F	p	Effect Size
Group Effect	2414.36	2	1207.18	4.50	.016	.15
Time Effect	1924.99	1.25	1543.98	1054.81	<.001	.68

Time × Group	930.48	2.49	373.16	25.47	<.001	.51

Table 2 shows that the main effect of time was significant ($p < .001$), indicating meaningful differences among pretest, posttest, and follow-up. The group effect was also significant ($p = .016$), and the time × group interaction was significant as well ($p < .001$). The effect size for the group effect suggests that 15% of the variance in self-efficacy is explained by group membership. Time effect accounted for 68% of variance changes, while the time × group interaction explained 51% of the variance in self-efficacy due to temporal changes in at least one group.

To further examine pairwise differences in self-efficacy across the three time points, the Bonferroni post hoc test was conducted, as shown in Table 3.

Table 3. Bonferroni Post Hoc Test Results for Self-Efficacy in Married Women

Reference Stage	Comparison Stage	Mean Difference	Std. Error	p
Pretest	Posttest	-7.03	0.69	<.001
	Follow-up	-7.83	0.70	<.001
Posttest	Follow-up	-0.81	0.28	.018

As shown in Table 3, the difference between pretest and posttest scores was statistically significant ($p < .001$), with a notable increase in posttest scores. A significant difference was also observed between posttest and follow-up scores ($p = .018$), with a slight increase at follow-up. However, since the Bonferroni test evaluates the mean across all three groups, the interpretation should be confirmed by examining the interaction graph of group and time effects.

Given that the group effect is based on aggregated mean scores and that both the main effects and their interaction were significant, the Bonferroni test was further used to analyze group-wise differences at each assessment stage. Table 4 shows the pairwise comparisons of mean self-efficacy scores in married women across the three groups.

Table 4. Pairwise Comparison of Self-Efficacy Mean Scores Between Two Groups at Three Assessment Stages

Stage	Group I	Group J	Mean Difference (I-J)	Std. Error	p
Pretest	Compassion-Focused	Solution-Focused	3.44	3.63	1.000
		Control	3.17	3.63	1.000
	Solution-Focused	Control	-0.28	3.52	1.000
Posttest	Compassion-Focused	Solution-Focused	-0.69	3.17	1.000
		Control	10.97	3.17	.003
	Solution-Focused	Control	11.67	3.07	.001
Follow-up	Compassion-Focused	Solution-Focused	-0.28	3.26	1.000
		Control	11.89	3.26	.002
	Solution-Focused	Control	12.17	3.16	.001

As shown in Table 4, Bonferroni post hoc results indicate that there were no significant differences in self-efficacy scores among the three groups at the pretest stage. However, in both posttest and follow-up stages, significant differences were found between the compassion-focused therapy and solution-focused therapy groups compared to the control group ($p < .05$). In other words, self-efficacy scores significantly increased in the experimental groups (compassion-focused and solution-focused therapy) during the posttest and follow-up stages compared to the control group. Furthermore, no statistically significant difference was observed between the two experimental groups at either the posttest or follow-up stages ($p > .05$).

These results indicate that both compassion-focused therapy and short-term solution-focused therapy are effective and sustainable in enhancing self-efficacy among married women. However, their effectiveness does not significantly differ from one another. Therefore, the research hypothesis is rejected.

Discussion and Conclusion

The present study aimed to compare the effectiveness of compassion-focused therapy (CFT) and short-term solution-focused therapy (SFBT) on self-efficacy in married women. The findings revealed that both therapeutic approaches significantly improved self-efficacy scores in participants at posttest and follow-up stages compared to the control group. However, no statistically significant difference was observed between the two experimental groups in terms of efficacy. These results suggest that while both CFT and SFBT are effective in enhancing self-efficacy in married women, neither method demonstrated superiority over the other in this context.

The significant increase in self-efficacy observed in the compassion-focused therapy group is consistent with a growing body of research emphasizing the positive impact of self-compassion on psychological well-being and self-perception. Self-compassion facilitates a reduction in self-critical thought and promotes a more balanced and accepting internal dialogue, which can, in turn, enhance one's confidence in coping with life's challenges. In this regard, the present findings align with previous research by Nasir-Herand et al. (2024), who found that CFT significantly increased self-efficacy and reduced rumination in married female university students (3). Similarly, Haji-Rostam et al. (2022) reported that self-compassion-based mindfulness therapy led to improvements in self-efficacy among overweight women by targeting internal shame and increasing self-regulatory behaviors (4). Asadi Bijaeyeh et al. (2021) also demonstrated that self-compassion training improved both resilience and life satisfaction in elderly women, suggesting a generalizable mechanism across different female populations (13).

Moreover, the observed effectiveness of compassion-focused therapy may stem from its influence on emotion regulation systems and the activation of the affiliative, care-giving motivational system. Research has shown that self-compassion buffers the effects of negative emotional states, including guilt, shame, and self-doubt—all of which can inhibit the development of self-efficacy beliefs. Efafdoost-Sani et al. (2024), in a study of neglected adolescents, found that self-compassion training enhanced emotional control, which is often closely tied to an individual's perceived capacity to handle difficulties (17). Similarly, Pedro et al. (2019) demonstrated that self-compassion acted as a buffer against the effects of self-criticism and negative automatic thoughts in postpartum women, again pointing to its utility in vulnerable populations (2). These mechanisms likely contribute to the increases in self-efficacy observed in the current study, as participants learned to respond to internal distress with kindness and resilience rather than self-judgment.

The solution-focused therapy group also exhibited significant improvements in self-efficacy from pretest to posttest and follow-up, reinforcing the notion that this brief, resource-oriented approach effectively fosters psychological empowerment. Solution-focused therapy encourages clients to envision preferred futures and identify existing strengths, thus mobilizing internal resources toward problem-solving and goal attainment. The current findings support those of Ghodsy and Sajjadi (2023), who observed that solution-focused group training significantly improved self-efficacy and marital satisfaction in married women (10). Similarly, Farahani et al. (2020) reported that SFBT improved emotional regulation and self-efficacy in

mothers of children with intellectual disabilities, suggesting its efficacy across a range of emotionally demanding roles (11). In another study by Bagheri et al. (2024), SFBT was found to be as effective as metacognitive therapy in enhancing self-efficacy among female students with social anxiety disorder (14).

The theoretical rationale for these improvements lies in SFBT's emphasis on identifying "exceptions" to problems and leveraging those to build forward momentum. This focus on what works rather than what is wrong appears to be particularly effective in empowering women, who often contend with culturally ingrained self-doubt or role strain in marital contexts. Jenkins and Germaine (2023) argued that solution-oriented learning models, including SFBT, promote motivation and resilience by highlighting individual agency (6). Ciydem (2024) also found that solution-focused thinking was negatively associated with difficulties in emotion regulation among nursing students, underscoring the cognitive-emotional mechanisms through which SFBT may operate (18).

Although the differences between the two experimental groups were not statistically significant, it is worth noting that both therapies may exert their influence through partially overlapping mechanisms. Both CFT and SFBT foster self-reflection, goal-directed behavior, and emotional regulation, albeit through different theoretical lenses. While CFT is rooted in evolutionary psychology and targets self-relational schemas, SFBT is grounded in constructivist theories and emphasizes narrative and cognitive restructuring. In this context, the lack of a significant difference may suggest that either approach is equally suitable for enhancing self-efficacy in married women, depending on the specific needs and preferences of the individual. Shariat-Zadeh-Jenidi et al. (2021) reported comparable outcomes in marital satisfaction using solution-focused couple therapy, supporting the notion that therapeutic relationship and client engagement may play a more critical role than the specific modality (16).

The results are further supported by Arianfar and Hosseinian (2019), who found that both solution-focused and self-regulatory therapies improved emotional control in distressed couples, highlighting that both approaches cultivate a sense of control and agency (21). Similarly, Alizadeh et al. (2024) found that self-compassion and marital self-regulation significantly predicted marital adjustment, suggesting that fostering internal self-support and regulatory capacities can directly impact relational and intrapersonal outcomes (1).

Furthermore, studies such as those by Kim et al. (2017), which used multilevel meta-analysis to evaluate the effect size of SFBT, support the conclusion that solution-focused interventions yield significant improvements across various psychological domains, including self-efficacy (19). The current study's results are in line with these findings and add to the growing evidence base supporting the use of both CFT and SFBT for enhancing psychological functioning in women. Moreover, Mir-Mahmoudi (2025) showed that self-compassion was positively associated with academic vitality and psychological hardiness in students, emphasizing the generalizability of self-compassion as a resilience-promoting factor across life domains (22).

Taken together, the findings suggest that both compassion-focused and solution-focused therapies are viable, effective, and durable interventions for enhancing self-efficacy in married women. The comparable outcomes between groups suggest that practitioners can flexibly employ either approach, taking into consideration client preference, treatment goals, and contextual constraints. These results not only confirm previous findings in the literature but also expand the understanding of therapeutic equivalence between two theoretically distinct, yet functionally complementary approaches.

While the findings of this study offer valuable insights, several limitations must be acknowledged. First, the sample was limited to married women who voluntarily sought participation through a cultural center in a specific geographic region. This limits the generalizability of the findings to broader populations, such as women in rural areas, those of different socioeconomic backgrounds, or individuals in clinical settings. Second, the dropout rate, although modest, slightly reduced the statistical power, particularly in the compassion-focused group. Third, all data were based on self-report measures, which can be influenced by social desirability bias and participant interpretation. Lastly, although the two-month follow-up demonstrated the sustainability of intervention effects, longer-term follow-ups would provide a more comprehensive understanding of the durability of the treatments.

Future research should explore the long-term impact of both CFT and SFBT using longitudinal designs with extended follow-up periods to assess the durability of their effects on self-efficacy. It is also recommended that future studies incorporate diverse populations, including different age groups, education levels, and cultural backgrounds, to increase external validity. Additionally, incorporating qualitative components such as interviews or focus groups could offer richer insights into participants' experiences and perceived changes following therapy. Exploring the combination or integration of compassion-based and solution-focused techniques may also be valuable in developing hybrid models tailored to individual needs.

Therapists working with married women who experience low self-efficacy may confidently apply either CFT or SFBT depending on client preferences, session availability, and therapeutic goals. For time-constrained or resource-limited settings, SFBT offers an efficient and practical option due to its brief and structured nature. On the other hand, for clients who struggle with internalized self-criticism or trauma histories, CFT provides a nurturing and emotionally reparative environment. Mental health professionals should be trained in both modalities to flexibly adapt their approach and optimize client outcomes. Community centers and marital counseling services are encouraged to integrate these evidence-based therapies into their programming to empower women in their relational and personal roles.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. This study was approved by the Research Ethics Committee of Islamic Azad University, Mashhad Branch, with the ethical code IR.IAU.MASHD.REC.1404.019.

Transparency of Data

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

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