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Prevention of Re-Experiencing Abusive Relationships: Development and Effectiveness of a Transdiagnostic Intervention Package—A Pilot Study

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Abstract

Objective: Re-experiencing abusive relationships is a distressing phenomenon, particularly among individuals with a history of intimate partner violence (IPV). This study aimed to develop and evaluate the effectiveness of a factor-based transdiagnostic package to prevent the re-experiencing of abusive relationships in Iran during 2020.
Method: This study was conducted in two phases. The qualitative phase involved in-depth, semi-structured interviews with seven experts and twelve patients from psychological clinics in Rasht, analyzed through content analysis. The quantitative phase utilized a semi-experimental design incorporating pre-test and post-test assessments with a control group. The population consisted of individuals referred to ten psychological clinics and three university counseling centers from 2018 to 2020. Out of 36 volunteers, 24 met the inclusion criteria and were randomly assigned into two groups of twelve. The intervention consisted of individual therapy sessions conducted bi-weekly over 16 sessions. A researcher-developed questionnaire was used to assess tendencies to re-experience abusive relationships in the quantitative phase.
Results: Qualitative analysis of expert interviews identified five key components essential for effective treatment of abusive relationship survivors: (1) the content of the sessions, emphasizing contextual and cognitive approaches alongside psycho-education, values clarification, and commitment to change (2) process factors, including a strong therapeutic relationship, client motivation, and giving hope; (3) the structure of the sessions, highlighting flexible frequency, continuity, and follow-up; (4) the characteristics of the therapist, such as expertise, self-awareness, and persistence; and (5) client-related factors like education, environmental stressors, and abuse history. In the quantitative phase, analysis of covariance (ANCOVA) revealed that the transdiagnostic therapy effectively prevented the re-experiencing of abusive relationships ($P < 0.001$).
Conclusion: This finding highlights the effectiveness of therapeutic interventions in reducing the recurrence of abusive relationships, indicating that factor-based transdiagnostic therapy may offer a promising approach to mitigating the risk of re-experiencing such relationships.

Key words: *Dating Violence; Domestic Violence; Intimate Partner Abuse; Spouse Abuse; Transdiagnostic Therapy*

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Re-experiencing abusive relationships is a distressing and often overlooked phenomenon, particularly among individuals with a history of intimate partner violence (IPV) (1). Abusive relationships are characterized by repeated and compulsive abusive behaviors which can be emotional, financial, sexual, or physical, or by neglecting the other person's needs to maintain power and control over an intimate partner (2, 3) These behaviors often occur within a persistent pattern of coercion, manipulation, and dominance, and can deeply affect the victim's sense of autonomy, safety, and psychological well-being (4, 5).

All types of abuse can lead to health problems for victims, with mental health issues being the most prevalent (32%) (6). Most reported mental problems are depression, anxiety symptoms with suicidal ideation, fear, insomnia, hypervigilance, and dysfunction. Substance abuse, guilt, passivity, and helplessness are the responses to the continuation of a relationship which is similar to the situation in which the person feels helpless, making any resistance struggle seem useless (7-9).

People who experience abusive relationships are more irritable and engage in antisocial and risky sexual behaviors along with other forms of interpersonal violence. In addition, consequences such as poor academic performance, personality disorders, eating disorders, emotional distress, self-blame, and lower self-compassion have been reported (3, 7-11).

Statistics show that intimate partner violence is a global issue. Half of Americans have been emotionally abused by an intimate partner at least once in their lifetime. 35.2% of college students in the United States have experienced dating violence. In South Korea, 50.8% of female students reported sexual violence and 12.5% reported physical violence. 49.2% of girls aged 12 to 18 in Turkey have experienced and reported sexual violence (12-14). In Iran, the highest rate of violence has been reported as 48.5% among women aged 20 to 30 years, while the lowest rate of violence has been reported as 9.6% among women in the age range of 45 to 50 years (12). Jafari and Parvin demonstrated in a review study that the most common type of violence against women in Iran is psychological violence, followed by physical violence(13) .

Although many individuals have become aware of the cyclical nature of neglect and abuse, the lack of education during adolescence about the signs of emotional and physical abuse in romantic relationships often leaves them vulnerable to repeated involvement in abusive relationships (15). Additionally, unresolved effects of adverse childhood experiences increase the risk of IPV victimization in adulthood (16). In Iran, due to insufficient attention to such education during adolescence and early adulthood, the experience of abusive relationships is notably widespread (17).

In the past years, therapists have used different approaches to prevent abusive relationships and treat people with abusive relationship experiences. So far, the effectiveness of cognitive-behavioral therapy (18), feminist treatment (19), compassion-focused therapy (20), and psycho-educational intervention approach on abused women (21) have been confirmed. However, despite all the efforts, the fundamental question remains: Why, despite the effectiveness of these treatments, is the incidence of violence still high? One possible reason is the failure to consider abusive relationships as a phenomenon influenced by various human psychological, social, cultural, and environmental factors. Research by Mirpour and colleagues (2021) on the localization of this phenomenon showed that abusive relationships are influenced by contextual conditions, causal conditions, maintaining factors, strategies and consequences, as well as intervening factors. The research highlighted factors such as fear of loss, self-doubt about one's observations and perceptions, inclination to justify individuals' behaviors, tendency to believe in love, emotional silence rights, low self-esteem, and feelings of guilt. On the other hand, favorable economic status, misuse by the opposite gender, sexual abuse (loss of virginity), parental knowledge of the relationship, and familial and societal pressures are factors that keep an individual in an abusive relationship. Among these, clingy behavior, submission, compliant reactions, misuse, overeating, self-destructive behavior, passivity, self-criticism, and on-off relationship strategies are behaviors and strategies that individuals manifest in abusive relationships (9, 12, 22, 23).

Conditions that appear to be effective for these strategies include family violence, patterns of abusive relationships in parental experiences, control, family betrayal, past experiences, rejection, and feelings of loneliness, as well as parental mental disorders (9). Since overcoming and ending abusive relationships are likely multi-faceted decision-making processes influenced by individual and social contextual factors (22). Therefore, many clinical practices avoid diagnosis-based treatments and instead prefer an integrative combination of therapeutic elements tailored to the presentation of each individual, as reflected in the formulation of each client's preferences. This practical approach makes it possible for adapting suitable interventions with the vulnerabilities and specific processes related to the individual and provides a flexible therapy model for a wide range of disorders (24). Recent research supports the effectiveness of transdiagnostic, eclectic approaches, which have been successful in treating victims of abusive relationships (7, 25, 26).

Transdiagnostic psychological interventions are divided into two general categories. The first category is universal interventions, such as the Unified Protocol (UP) for the transdiagnostic therapy of emotional disorders, which promote the same approach for all, in

which all clients receive the same set of therapy elements. Their clinical application is easy because there is no custom selection of intervention elements. The second category is modular approaches to treat anxiety, depression, and trauma that target a similar range. Providing modular interventions is more challenging than providing universal protocols and requires algorithms that match the implementation of the models to the individual needs of each client and are adjusted accordingly. However, this approach will enhance the alignment between treatment strategies and an individual's clinical manifestations (24). The approach is based on reviewing the studies of causal cognitive theories of abusive relationships including social learning theory, biopsychosocial theory, and traumatic bonding theory (27). Treatment in traditional diagnostic categories has typically been tailored to the presenting symptoms. For example, in cognitive-behavioral therapy, interventions for obsessive-compulsive disorder or marital problems often focus on modifying core beliefs. However, such approaches do not necessarily consider whether individuals with OCD, for instance, experience unique characteristics that are absent in individuals dealing with marital conflict. In these models, treatment is not customized based on the specific needs of the client; rather, it is the client who is expected to align with the assumptions and strategies of the therapeutic approach (28, 29).

The present study seems necessary considering the literature review and the existence of a research gap in the field of effective interventions of localized transdiagnostic therapy and considering the prevalence of abusive relationships and the resulting psychological, social, and economic consequences. Therefore, the purpose of the present research was to determine the formulation of a factor-based transdiagnostic therapy package and its effectiveness in preventing the re-experiencing of abusive relationships. This research sought to answer the question: "Does participation in a factor-based transdiagnostic therapy package significantly reduce the likelihood of re-experiencing abusive relationships among adults in Iran?"

Materials and Methods

Study Design and Objectives

The present study is applied in terms of its aim and was conducted in two phases, including a quantitative part of the semi-experimental type with a pre-test and post-test design with a control group and a qualitative content analysis with the formulation of a factor-based educational program.

Phase One

The first phase was involved formulating the educational package in three steps. In the first step, semi-structured interviews were conducted with seven experts and 12 people with experiences of abusive relationships referred from psychological and psychiatric clinics in the city of Rasht, using a purposive sampling. The process continued until data saturation was reached (30).

The data were collected using semi-structured interviews, observations, and field notes (31). The interviews were conducted in a quiet and comfortable room, and participants with experience in abusive relationships were asked to share their experiences with psychological treatments. Questions included: "What professional help did you receive after experiencing an abusive relationship?" "What are your thoughts on the effectiveness, limitations, and strengths of these methods?" "Did the number and frequency of sessions impact recovery?" "How important are support resources like family and friends?" "How would you evaluate the impact of the therapeutic relationship on the recovery process?" These questions were followed by further inquiries.

Another method for data collection was interviewing experts in the field of psychology. Interviews were conducted with 7 interested and experienced specialists in the field of abusive relationships. After sending an official letter to provide explanations concerning the objective of the present research, the interviews were held at their office locations. To activate the participants' minds and receive the best responses, a brief research overview and explanation were provided to them a few days prior to each interview. Additionally, in order to ensure the best responses to the interview questions, several preliminary questions were asked before the main question, "What is the best treatment method for abusive relationships?" Each interview began with the question: "Based on your clinical experience in treating victims of abusive relationships, when do you consider an individual to be considered healed or recovered?" and "Which therapeutic approaches do you utilize most in treatment?" The advantages and disadvantages of these methods, as well as their effectiveness, were also discussed.

At the end of each interview, the participant was thanked and appreciated, and they were asked to share any remaining thoughts or comments. The data were collected using the Colaizzi method in several stages. First, the interview was carefully transcribed word by word. To ensure the accuracy of the transcriptions, they were reviewed again. Then, the entire experience reported by the participant was read to understand the general sense of it. In the next step, important sentences related to the participants' experiences were extracted from each interview, and the context of each sentence was written by the researcher. Meanings and themes were identified and organized into clusters based on their general concepts. Initially, sections of the content that seemed related to each other across the reports were identified, and the relationships between the parts or the overall content were clarified. Then, by merging the themes and clusters extracted from the notes, the language of the participants was translated into scientific language and concepts, leading to a comprehensive

understanding of the experiences and the phenomenon under study. Consistency and reliability of the findings were ensured by aligning the notes and raw findings, noting the text and context of the participants' statements, and using audio recordings during the interviews. Active listening to the participants' conversations, the researcher's prior experience, prolonged engagement with the participants, and the use of feedback from other researchers in the field all contributed to the validity and acceptance of the data in this stage of the research.

The second step of phase one included the review of the literature and the third step was to integrate the information obtained from steps 1 and 2 in response to the main question in developing the therapeutic package, which is "What are the components of the factor-based transdiagnostic therapy in preventing the re-experiencing of abusive relationships "?

Based on research literature, the localized model of abusive relationships proposed by Mirpour *et al.* (9), and the experiences of clients and experts, techniques from short-term psychoanalysis, short thematic relational therapy, cognitive and emotional therapy duration, schema therapy, and the acceptance and commitment approach were analyzed using the Colaizzi method and qualitative content analysis, leading to the extraction of a paradigm model through axial and selective coding.

In this step, the data extracted from the previous two stages were combined using axial and selective coding methods within a pattern model (paradigm) to develop a coherent and logically integrated treatment model or plan. Following this development, the treatment package was reviewed for content by nine experts in the relevant variable.

Phase Two

In the quantitative phase, the statistical population of the study included all the victims of abusive relationships who were referred to 10 psychological clinics and three university counselling centers in the city of Rasht from 2018 to 2020. The researchers obtained the approval of 10 clinics and three university counselling centers to review the valid files out of 13 files, eliminating unavailable samples. Over the past two years, they successfully collected 36 case files for analysis. After obtaining a history and considering the inclusion and exclusion criteria, 24 participants were screened by semi-structured interviews, clinical interviews, demographic information, and a researcher-made questionnaire on abusive relationships (scoring above the mean of the questionnaire; above 186)(32) .

Randomization

Subjects were randomly assigned in a 1:1 ratio to either the intervention or control groups. Randomization sequence was created using a computer-generated randomization system (Sealed Envelope: Sealed Envelope Ltd., London, UK) using a block size of four.

Sample Size

At first, the sample size calculation was performed for an independent sample t test using G*Power version 3.1.9.2 (33). Since we planned to incorporate the pretest score in the data analysis using analysis of covariance (ANCOVA), we multiplied this number by a design factor of (1 - ρ2), where ρ is the correlation coefficient between the pretest and posttest scores (34). With an effect size of 1 (Cohen's d) for TREARS score, a power of 0.8, an alpha value of 0.05, and using r = 0.6 to account for the correlation between pretest and posttest scores, 11 subjects would be necessary in each group. Assuming a potential drop-out rate of 10%, 12 subjects were needed in each group.

Inclusion / Exclusion Criteria

Inclusion criteria include obtaining a score above the average in the Abusive Relationships Questionnaire, an age requirement of 20 to 40, completing the consent form to participate in research, having no drug dependency and psychiatric drug use, with at least a high school diploma to understand and use the given therapy methods and receiving no simultaneous psychological interventions. The exclusion criteria were absenteeism more than two sessions .

Study Setting and Procedures

The research environment of the study was Bahar Clinic in the city of Rasht. The participants completed the Tendency to Re-experience Abusive Relationships Scale (TREARS) twice, before and after the interventions. The interventions mentioned in Table 1 were conducted individually during sixteen 1.5-hour-sessions for the intervention group participants. The control group received no interventions. The stages of the current study implementation are presented in Figure 1.

To comply with ethical principles, the researchers committed to carrying out this intervention for the control group after the end of the research. A summary of the executive instructions of the transdiagnostic therapy package sessions is presented in Table 1.

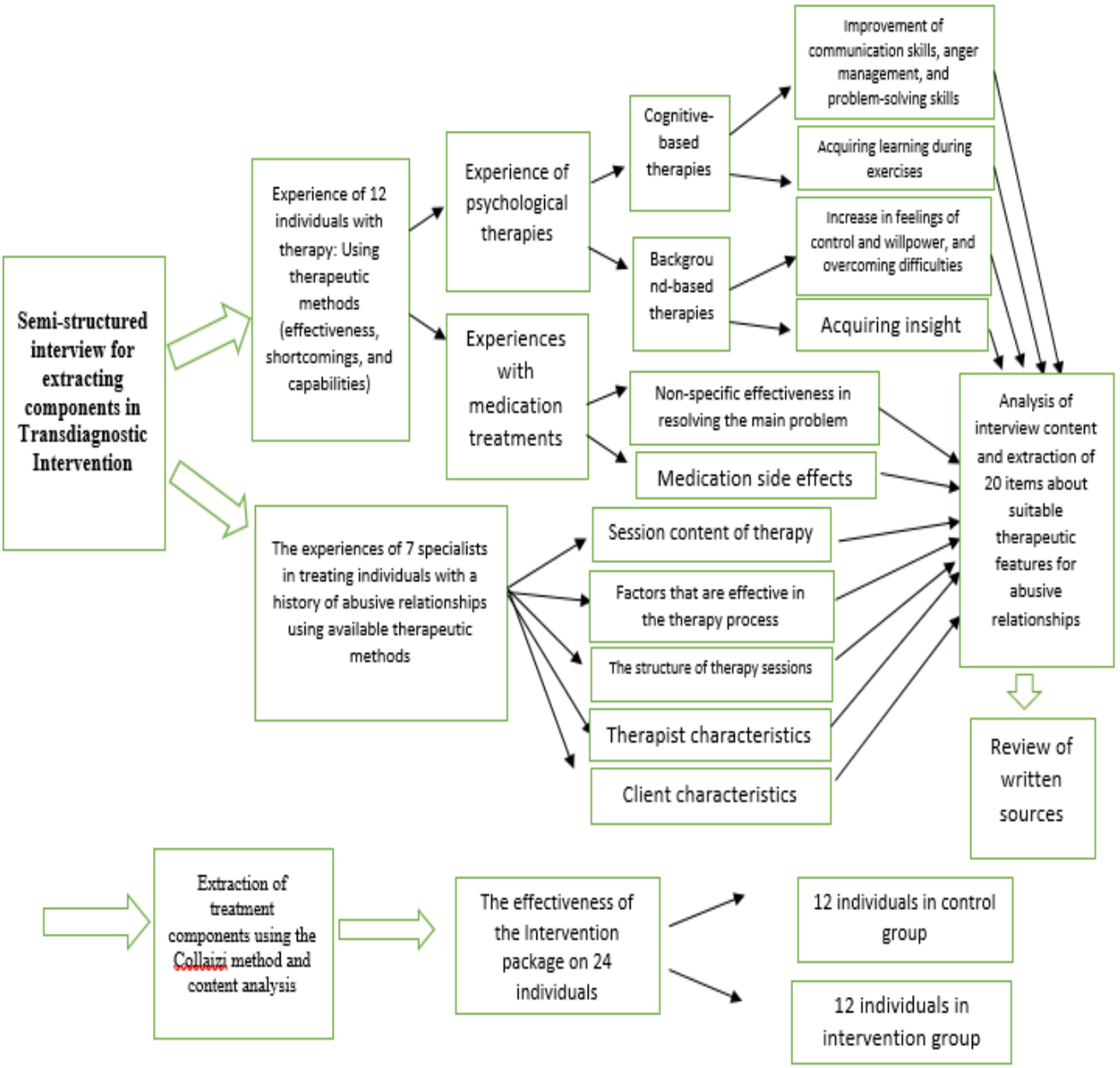

Figure 1. Flowchart of Study Stages for Developing and Evaluating a Transdiagnostic Intervention to Prevent Re-Experiencing Abusive Relationships

Table 1. Summary of 16 Sessions of 120 Minutes of Transdiagnostic Therapy to Prevent Re-Experiencing Abusive Relationships

Session	Subjects	Session Aim
1	Examining the conflict triangle	Recognizing and examining one's conflict triangle, drawing a conflict triangle, identifying one's defense mechanisms, one's anxiety and emotions
2	Examining one's triangle	Recognizing and examining one's triangle, drawing one's triangle, examining one's attachment, using reopened emotional and cognitive materials to analyze oneself, and strengthening one's insight

Session	Subjects	Session Aim
3	Schema training	Teaching Schemas: Abandonment, Defectiveness/Shame, Emotional Deprivation, Subjugation/Self-sacrifice, Dependence/Incompetence, Insufficient Self-control/Self-discipline, and presenting pamphlets to study at home
4	Mode training	Teaching the schema modes of a vulnerable child, angry child, impulsive child, compliant surrender, detached self-soother, happy child, healthy adult and presenting pamphlets to study at home
5	Cognitive, behavioral, and experiential interventions aimed at learning how to identify the Vulnerable Child mode – gaining insight into emotions, bodily sensations, cognitions, and basic needs, and linking these to the client's personal history	Awareness of the child's modes through mental imagery, exploring the relationship with parents and rules regarding behavior through the implementation of mental imagery, empathizing with the vulnerable child's mode through chair work, drawing the messages of the vulnerable child.
6	Cognitive, behavioral, and experiential interventions targeting the Angry and Impulsive Child mode, along with the provision of worksheets to be completed as homework	Warming up the angry child's modes by creating frustration in role-playing, empathizing with the angry child's modes through chair work, learning to be honest while setting boundaries through role-playing, from anger to assertiveness using the chair work technique.
7	Cognitive, behavioral, and experiential interventions targeting maladaptive coping modes, along with the provision of worksheets for homework assignment	Depicting the coping style through role-playing, conceptualizing the case experience by examining the advantages and disadvantages and supporting beliefs of coping modes and the antidotes of the healthy adult mode, empathic confrontation with maladaptive coping schema modes through the chair technique.
8	Cognitive, behavioral, and experiential interventions targeting the Ineffective Parent mode, along with the provision of worksheets for homework assignments	Becoming aware of the parent schema mode and forgiving the child through role-playing, overcoming the parent schema mode through regulated anger with the chair technique for the parent schema mode, establishing communication with early schemas and identifying inner reactions, and reconstructing trauma related to various topics through role-playing.
9	Cognitive, behavioral, and experiential interventions targeting the Happy Child mode, along with the provision of worksheets for homework assignments	Reconstructing memory process, teaching exaggeration, positive feedback worksheet for the happy child modes.
10	Cognitive, behavioral, and experiential interventions targeting the Healthy Adult mode, along with the provision of worksheets for homework assignments	Spontaneity in reconstructing the schema mode, discussing behavior change through role-playing, making promises to the child mode through the chair technique, drawing the model of the modes.
11	Adopting a self-observational perspective, and cognitive diffusion interventions	Viewing thoughts, naming thoughts, letting go of thoughts, distancing oneself from thoughts, combining watching, writing and letting go of thoughts
12	Mindfulness strategies	Mindfulness training in daily activities, being mindful of breathing, being mindful of thought and emotion

Session	Subjects	Session Aim
13	Values Clarification - values-based goal setting and activity design	Preliminary assessment of values, description of the nature and function of values, differentiation of values from goals, process versus outcome, value clarification exercises, value clarification tools, and homework assignment to set a goal, planning an activity
14	Creating bigger models and committed action	External and internal barriers, giving another commitment in case of breach of contract
15 & 16	Deal with comprehensibility, persistence, control, guilt, shame, and acceptance	Identifying troublesome emotional schemas, labelling emotions, and differentiating them from other probable emotions, normalizing emotions, realizing that emotions are transient, increasing emotion acceptance, tolerating mixed emotions

Assessment Tool

The Tendency to Re-experience Abusive Relationships Scale (TREARS) was developed using Iranian samples. This questionnaire is set in 52 items and in the form of a Likert scale from "Completely Agree = 6" to "Completely Disagree = 1". The minimum and maximum scores are 52 and 312, respectively. In examining a suitable point for predicting abusive relationships, the best cut-off point was determined to be 166. This tool measures 18 domains of abusive relationship experience, including lack of knowledge, ignoring oneself to maintain the relationship, using the relationship for improving economic status, self-blame, cultural pressure, lack of reliability, belief in changing through love, mythical belief in love, toleration of frustration due to love, social pressure, hesitation in decision-making, fear of abandonment, family pressure, using the relationship for progress, gender superiority, the magical effect of love, fear of loss, and self-doubt. The high score in this questionnaire identifies people who have experienced an abusive relationship and also predicts the recurrence of such relationships. The face validity of this questionnaire was confirmed by experts. Cronbach's alpha coefficient of the questionnaire was 0.869. The stability of the tool over time has been 0.929, which is statistically significant (P = 0.001). The reliability coefficient of the test-retest was 97.05% and the reliability coefficient of the test-retest of all areas was above 0.90. The validity of the tool structure was examined in two parts: the power of differentiation of the tool and the equivalence of the two tools. The results of the Independent t-test showed acceptable differentiation strength in both groups (P = 0.03) and there were significant differences between the two groups in almost all areas (P < 0.05), indicating that the TREAR-Persian scale has good psychometric properties (32). In another study, the Cronbach's alpha coefficient of TREARS was reported at 0.90 (11).

Statistical Analysis

In the present study, continuous variables are expressed as mean (standard deviation (SD)) and categorical variables are expressed as n (%). An ANCOVA with pretest score as covariate was performed to investigate difference between the control and intervention groups at posttest measurement. The effect size for ANCOVA was reported in partial eta squared (η^2_p); η^2_p values of 0.01-0.06, 0.06-0.14, and > 0.14 were considered small, medium, and large effect sizes, respectively (35). Before the ANCOVA model building, the assumptions of ANCOVA (i.e., homogeneity, linearity and normality) were examined. Data analysis was conducted using SPSS for Windows, version 16.0 (SPSS Inc., Chicago, IL, USA), and a graph was depicted using GraphPad Prism, Version 8.0.1 (GraphPad Prism Software Inc., San Diego, CA, USA). The significance level was set at 0.05.

Ethical Consideration

The participants were provided with the necessary explanations regarding the objectives of the study, and if they expressed consent, the time and location for the interview were determined with their agreement. The interviews were conducted by the first author in the clinic's consultation room, and no one was present in the room during the interview, ensuring that the privacy of the individuals was fully respected. At the beginning of each interview, the purpose of the interview was reiterated, and permission was obtained for audio recording, participation in the interview, and answering the questions. Informed written consent was also obtained from the participants for their involvement in the research. The participants were reassured about the confidentiality of the information and the recorded audio, with the assurance that all their information would be reviewed solely by the primary researcher and kept strictly confidential. The results would be presented in a generalized format without mentioning any names.

This paper is extracted from the doctoral dissertation of the first author and approval was obtained from the research of ethics committees of Islamic Azad University-Tonekabon branch (approval no. IR.IAU.TON.REC.1399.026) on 07/09/2020. All methods were carried out by the 1964 Helsinki Declaration. Informed consent was obtained from all the participants.

Results

Findings of the First Stage:

How have people involved in abusive relationships experienced therapy methods and what do they think about the effectiveness, defects, and capabilities of these methods?

The participant's experience of the effectiveness of psychological treatments could be categorized into two categories, namely cognitive psychological treatments and contextual therapies.

The Effect of Cognitive Psychological Treatment Methods

The participants' points of view and experience of the effects of cognitive therapy strategies have been identified in two axes.

A) The initial feeling and experience lead to developing positive feelings towards overcoming the problem, but in a relatively short period, past experiences dominate, and the person is faced with a feeling of inadequacy from not being able to stop the repetitive cycle of experiencing abusive relationships and helplessness. For example: "It was good when I started going to the therapy sessions; it gave me hope that I would not experience such a relationship again, but a year later I found myself in the middle of another relationship with the same situation just like before," said participant No. 7. Participant No. 6: "It took me several sessions to convince myself that I want to do the therapeutic strategies… I didn't believe in them… I would tell myself they're of no use!", Participant number 5: "The techniques were as if everything was supposed to be simpler than what I had experienced, and now the more time passes, the more I believe in it."

B) The effects of the package can be classified into two categories:

1. Improvement of communication skills, anger control, and problem-solving was among the positive effects of cognitive therapy, which were mentioned by the participants and they consider it to increase their self-confidence. For example, "Doing the exercises made me have more control over my communications ... Now I'm able to control my anger and I show it appropriately; for example, I tell the other person about my feelings", says participant No. 2. Participant No. 5: "My therapist was very good at confronting me with my problems in expressing my needs and not being able to say no, and showed me good strategies and solutions."

2. Learning during exercises

One of the most important advantages of cognitive methods was to develop a kind of learning in the participants, leading to the transformation of faulty cognitive structures and the enhancement of decision-making and risk-taking abilities. This experience was valuable for the victims of abusive relationships, helping them develop healthier thought patterns. The participants shared their takes and experiences, Participant No.4 stating: "I faced my illogical thoughts and then I was able to find logical alternatives for them...this learning experience was a miracle for me." Participant No. 6 said, "Many things were added to me in this course. I got to know my emotions and their impact on my thoughts. It was great. Many questions in my mind (while facing a problem) were answered." Participant No. 5 stated that: "With the things I learned in therapy, I'm able to analyze the illogical and logical thoughts and find my emotions just before any behavior happens on my part, and... this has helped me many times to make decisions... This is just great!"

The Effect of Contextual Therapy Methods

Participant's points of view regarding the therapeutic effects of contextual methods can be classified into two categories:

A) What participants experienced regarding the effectiveness of contextual therapies was to increase the sense of control and willpower and overcome the problem. Besides satisfactory statements, the participants noted the control gained over initial feelings of anger and anxiety during therapy. For example, "I remember that a few sessions after my therapy started, I experienced a huge amount of anxiety. Many old memories with painful feelings came up. But the therapist helped me get over it during that period," said participant No. 9. Participant No.8 stated that: "It took a while, but... many times at the beginning of the therapy I thought I was going to lose everything I had. I mean, my view of myself, my life story, and the people around me changed. It couldn't have been better than this to understand what happened to me and how I got involved in the story... I was able to control my problems very well."

B) The participants declared that they Gained some kind of insight and learning during the therapy. Participants' experiences demonstrate that contextual therapies strengthen their introspection and self-knowledge. In other words, they realized why they behave in a certain way. Participant No. 10 stated: "That's what everyone needs! When you understand where your problems stem from and how you react to them, it's easier to understand them and do the right thing." Participant No. 8 said: "The connection between what is happening now and what I experienced with my parents brought me to a strange realization. This understanding and awareness hurt, but nothing could help me stop the wrong people from coming into my life!"

Medication

The participant's experience of the effectiveness of the treatments of people involved in abusive relationships could be categorized into two

categories of therapeutic effects and drug side effects.

a) In terms of the effects of medications, some participants considered the effect of the drug to be limited to increasing mood and reducing anxiety, and they believed that the drug did not have any specific effect on re-experiencing the next possible abusive relationship. For example, "The medicine was not effective... It was all because of some other reasons; it didn't even reduce my anxiety... Nothing...," said Participant No. 1. Participant No. 2 stated: "I'm afraid of separation... I was in a bad mood; I was anxious and sad! The medicine helped me... Maybe it reduced my anxiety! But it didn't do much." Participant number 3 said: "I took medicine for several years, but when I saw that it had no effect in solving my problems, I gave it up. I had to learn what to do with my problems."

Some participants described the positive effects of the drug. Participant No. 11 said: "The drug calmed me down… my anger… my depressive mood was no longer the same as before; I wasn't feeling bored or dull."

b) Medication side effects

Some participants mentioned the side effects of the medication that led to deciding to stop taking it. For example, Participant No. 3 declared: "I was sleeping too much; I was sleeping all the time...I wondered if I had to depend on these things forever?". Participant number 1 said: "Medications didn't help me... Vomiting... Trembling of my hands… I stopped taking them on my own decision."

Apart from the content of the conversations with the participants, some other factors also contributed the acceptance of treatment techniques and strategies and their effects. These strategies can be categorized into several subgroups:

1- Motivation and Hope

The participants emphasized the importance of motivation and giving hope to clients to accept therapeutic exercises. According to them, clients must be highly motivated to accept any type of treatment; otherwise, even if the most suitable treatment is provided, it will be ineffective in helping the clients. For example, "I thought that I should accept it as a part of my destiny... Well, I thought to myself this was how it was going to be for me, just my luck! But the doctor's words gave me hope. I said to myself, let's try it," states Participant No. 12." Participant No. 2 said: "I can't take it anymore. I want peace... I tried everything, but it didn't work. Counselling was my last hope. And the words of my psychologist in the first session made me go to the next session as well... it's like he knew a way for me to get out of this situation."

The experience of the participants regarding getting motivated in the treatment was with strategies that are mentioned below.

2- The Importance of Trusting the Therapist

The participants emphasized the therapist's ability and professional expertise in applying the therapy methods, the therapist's ability in persuading the clients, the therapists' decisiveness and the ability to empathize with the clients, and the non-judgmental view. For example, "The doctor was able to help me trust the therapy very well. His questions in the first two sessions made me feel that she was checking the situation thoroughly," said Participant No. 8. Participant No. 5 stated: "I always received a sense of empathy from her (the therapist). This was a feeling that I never had experienced with anyone before. My family and friends always blamed me for everything; *why do you tolerate it, you asked for it, let it go*! ...But my therapist understood me and that made me trust her."

3- The Importance of Psycho-Education

Participants pointed out how important psycho-education was in understanding the development and consequences of abusive relationships and considered it highly effective in accepting the problem and therapeutic techniques. They also pointed out the importance of using strategies that can separate the disorder from the person so that people involved in abusive relationships accept the problem as a reality apart from their identity and this will increase their self-confidence and effort to do homework and treatment strategies suggested in them. For example, "It was great... that I understood what parts of my story could be solved with each technique because I understood the reasons for the problems I was experiencing in my relationships," said Participant No. 9. Participant No. 10 said: "I thought that this was my destiny and that I was doomed to always experience wrong people, but with the training I received from my therapist, I started to believe that I could control (situations) and I am not doomed to have toxic relationships." Participant No.7 stated: "One of the things that made me commit to therapy was remembering the values in my life."

4- The Importance of Values

The participants emphasized that recognizing and prioritizing personal values and life goals played a critical role in both the therapy and the prevention of re-experiencing abusive relationships. For example, Participant No. 6 stated: "When my therapist helped me recognize my values and I realized that every time I acted against my values, it made me feel bad... I would do anything to take away the things that prevent me from achieving my values away."

5- The Importance of Family and Friends

Understanding and assistance of family and friends are the things that some of the participants mentioned regarding the importance of its effectiveness during therapy. For example, Participant No. 2 sated: "I think that if my family and friends understood how to look at my problems, many of my problems would be solved.".

Factors Related to the Structure of Therapy Sessions:

One of the important things mentioned by the participants was the way of presenting the therapy methods and the structure of the therapy sessions. Things that were emphasized in terms of the structure of the therapy sessions include:

1- The number and interval of therapy sessions. According to the participants, a gradual therapy plan must be scheduled. Participant No. 8 said: "The session should be held more than once a week; it is true that financial issues are some kind of pressure, but it is not a small issue because a person's whole life depends on their romantic relationships and to develop a proper relationship, one should spend enough time.". Participant No. 9 stated: "My old and annoying story could not be solved with a few short sessions. People with problems similar to mine should have longer sessions with shorter time intervals!"

2- Importance of therapy follow-ups. The participants mentioned the importance of follow-up in preventing the re-experiencing of abusive relationships and stability in the therapy outcomes. For example, Participant No. 8 said: "After 8 months, I go once a month now, and I think I really need it. Sometimes, it's only my therapist who can help me stay committed to the therapy by reminding me."

The Second Sub-Question:

What is the experience of experts regarding treating people with abusive relationship experiences using existing treatment methods? To answer this question, the concepts extracted from the interviews were classified into specific categories based on their similarities and differences, then the similar categories were placed under a more general title and the general axes were named based on the related content. Finally, a table with 20 items was designed based on the findings of the qualitative content analysis, with each item rated on a 0 to 4 scale. Then, this form was returned to the participants to confirm the content extracted by the research participants. Additionally, the experts were asked to evaluate the importance of each item. After analyzing the content of the interviews, 20 items were designed, and after collecting experts' opinions about the importance of the items, only one item with an average of less than two was removed, leaving 19 items.

In general, five main axes were identified for developing the model from the content of the interviews. According to the professors, the points to consider were: 1- The content of the sessions, 2- Process factors, 3- The structure of the sessions, 4- The characteristics of the therapist, 5- Factors related to the client

1- Content of Therapy Sessions

Based on the findings obtained from the interviews with the experts, the content of the sessions included 5 main categories that were necessary according to the participants in the research. These categories include: a) using contextual therapy, b) using cognitive therapy, c) psycho-education d) clarification of values e) commitment to values-oriented practices, and commitment to therapy.

a) Using contextual therapy

All the participants in the current research emphasized contextual therapies as the main method of therapy. The experts' opinions indicated that the main method for treating abusive relationships is contextual therapies, based on both research evidence and professional experience. In fact, those types of treatments were advocated that regarded the client's problems and unresolved issues are rooted in the past and that the person's past experiences are the source of current emotional problems. Moreover, this therapeutic approach facilitates the healing process of past wounds and removes growth obstacles, thereby preventing the repetition of harmful and inefficient patterns. Experts believed that no therapist should hesitate to use this method in therapeutic interventions for people involved in the experience of abusive relationships.

Examples of participants' statements are mentioned below.

Expert No. 2: "In therapy, we must return to the client's childhood issues; childhood analysis. The least we should do is to work on their schemas because the roots of today's choices lie in the stories of the distant past.". Expert No. 5: "We must work on the consequences of the type of parent-child relationship that has caused harm to the individual. We must go into the past; we must investigate the deeper roots of parent-child relationships. The past is an important part of therapy that cannot and should not be ignored."

b) Using cognitive therapy

Paying attention to the cognitive aspects of clients and correcting cognitive distortions as another part of the therapy model was of interest to the participants. In this regard, the experts emphasized the auxiliary but important aspect of cognitive methods compared to contextual therapies. For example, expert No. 2 stated: "You have to focus on their cognitive skills. They have to know not to

expect care from the outside! They have to recognize their bad feelings...recognize their thoughts."

c) Psycho-education

One of the things mentioned by the participants was the emphasis on psycho-education as an important part of every therapy. Psycho-education includes information regarding the nature of the problem and how it has developed, stating the logic of the therapy, providing the necessary information to the patient to clarify the type and level of their expectations and their tasks in the therapy, which according to the participants' statements can affect the level of acceptance of the therapy and doing their homework effectively. All nine participants mentioned the importance of psycho-education and considered it effective in clients' level of commitment in doing homework.

For example, expert No. 5 said: "Teaching where the client's problem stems from and what consequences it has and will have is an important part of the therapy."

d) Clarification of values

Values give meaning and direction to life. Clarification of values helps clients identify values and face obstacles. The research participants believed that when clients come in contact with central values and commit to a values-oriented living, they will stop resorting to behaviors that are based on old patterns. Expert No. 3: "I often start with values...it works like a slap! It creates motivation for change!"

e) Commitment to values-oriented practices and commitment to therapy

According to the participants, committing to therapy occurs when the client engages in the overtly important responses to which they have devoted their entire life. This includes behaviors that the client previously avoided or skills that they have just learned. They prepare to behave in line with the discovered values and practices they have learned in therapy to overcome obstacles and be flexible enough to act on them. And this is a sign of recovery and makes it possible for the therapy to survive. For example, expert No. 1 stated: "They begin...despite all the difficulties, all the social and family pressures, and don't distance themselves from what they have achieved in the therapy". Expert No. 4 said: "When she got to know the roots of her problem, she became aware of her values. We expect that wherever she strays from this path, she catches herself at it and commits to her therapy."

2- Process Factors

The second axis that was extracted from the statements of the participants in this part of the research included factors related to the therapy process and included three categories. These include: a) the importance of therapeutic relationship, b) the importance of the motivation for therapy, c) methods of inducing a sense of hope.

a) The importance of the therapeutic relationship

Among the process factors, the therapeutic relationship has been mentioned as the most important component by all the experts. For example, expert No. 6 stated: "In this therapy, the therapist's relationship with the client should act as a parental relationship... a parent who is healthy and can be a supporter. Encourage the strengths and help the weaknesses to be resolved". Expert No. 4 said: "Without a therapeutic relationship, nothing can be done, just like other problems and disorders. Many wrong things in the client's life will be corrected automatically with this therapeutic relationship." Expert number 5 declared: "Therapeutic relationship is an important part of the story, the part whose importance is undeniable. The therapist is a healthy ego of the story, the ego that the client sees and that is the therapy itself."

b) The importance of creating motivation and hope

Motivating the improvement and continuing therapy was one of the significant topics according to all the participants. For example, expert No. 3 stated: "Giving hope is an important aspect of the process. Because the clients themselves have lost all hope and consider their situation as their fate!"

c) Methods of inducing a sense of hope

The participants emphasized the power of allegory and storytelling to help clients understand the techniques presented in the therapy and accept the logic of the therapy. They highlighted the importance of paying attention to clients' abilities and their strengths, encouraging them to see the problem as something outside of them so that the clients do not seem condemned to experience a vicious cycle. Additionally, understanding resistance and synchronizing with clients were seen as crucial in enhancing clients' ability to overcome obstacles. Expert No. 3 stated: "By any helpful metaphors and similes, the client should be given hope that they can overcome their problem. And it's not a certain fate that they're condemned to. The problem is outside of them. They should not be ashamed and feel guilty."

3- Structure of Therapy Sessions

One of the opinions of the experts in developing the transdiagnostic therapy model was the structure of the therapy sessions, which included 3 categories: a) the number and intervals of sessions, b) the importance of follow-up, and c) termination.

a) Number and intervals of therapy sessions

According to the participants, the number of therapy sessions and the interval between them should be regulated in such a way that it brings the most effectiveness and the least chance of leaving for the clients. For example, expert No. 1 declared: "At the beginning of the therapy, I think it can be twice a

week, and gradually it will be adjusted to once a week, once every two weeks, and once a month". Expert No. 7 said: "This type of client needs to have sessions more than once a week to overcome the initial crisis, and after a while, it can reach once a week."

b) The importance of follow-up

The participants presented some explanations regarding the importance of follow-up in preventing relapse and the stability of therapy results. For example, Expert No. 3 declared: "Follow-up and staying in contact with the therapist can prevent any re-experience."

c) Termination

Lack of support for the mental health system, as well as the attitude of clients towards therapy (in terms of lack of psycho-education), are considered one of the factors that contribute to premature termination of therapy.

Expert No. 4 stated: "Well, on the one hand, we are sure that their problems have childhood origins and should be investigated and examined; on the other hand, many of our clients cannot stand the fact that they should come for long sessions or they have financial problems in paying the therapy cost. Insurance doesn't cover our services.".

4- Characteristics of the therapist

Another significant topic based on the statements of the participants was the characteristics of the therapist. The following categories are the characteristics of the therapist according to the participants.

- Personal and personality characteristics: in this regard, therapists' self-awareness, information, and honesty were mentioned, as well as professional capabilities including the level of experience and expertise and educational qualifications. For example, expert No. 4 said: "Well, we want a therapist who is enthusiastic enough because we have many complications and ups and downs in the therapy of this group of clients. We should not get disappointed. At the same time, the therapist must also have sufficient knowledge... during the therapy process. The therapist will surely face the client's resistance and should accompany them with enough skill and knowledge." Expert No. 7 declared: "I think honesty and timely feedbacks from the therapists can help the clients in the process of self-discovery. Correct and appropriate feedbacks from the therapist help them!"

5- Characteristics of the Client

The characteristics of the client as a determining factor in choosing the therapy method and influencing the outcome were coded in three axes.

a) The individual characteristics of the client include the level of education and cognitive ability, language, and level of education. For example, expert No. 6 said: "It is very clear that the higher the education and linguistic and cognitive abilities of the clients of this group, the better and easier their relationship with therapy."

b) Environmental stressors include environmental pressures of clients, which can be considered one of the factors influencing the outcome of the therapy. For example, expert No. 1 stated: "The disturbances of the family itself can be a source of stress for the individual. Family and friends can be an important source of support in addition to therapy; otherwise, they turn into environmental stressors!"

c) History of conflict and experience of the client with an abusive relationship

In the majority of the participants, the abusive relationship was one of the important factors in the individual's characteristics, which can affect the result of the individual's treatment. For example, expert No. 2 said: "It can be seen that the longer the patient's years of conflict, the easier they give in to the therapy and accept it."

The answer to the main question which was about the components of factor-based therapy required the consolidation and integration of all the findings in the previous steps (interviews and literature) and establishment of the relationship between each of the components. This became possible by using the axial paradigm (Figure 2). The content validity of the package was confirmed by three psychologists and consultants.

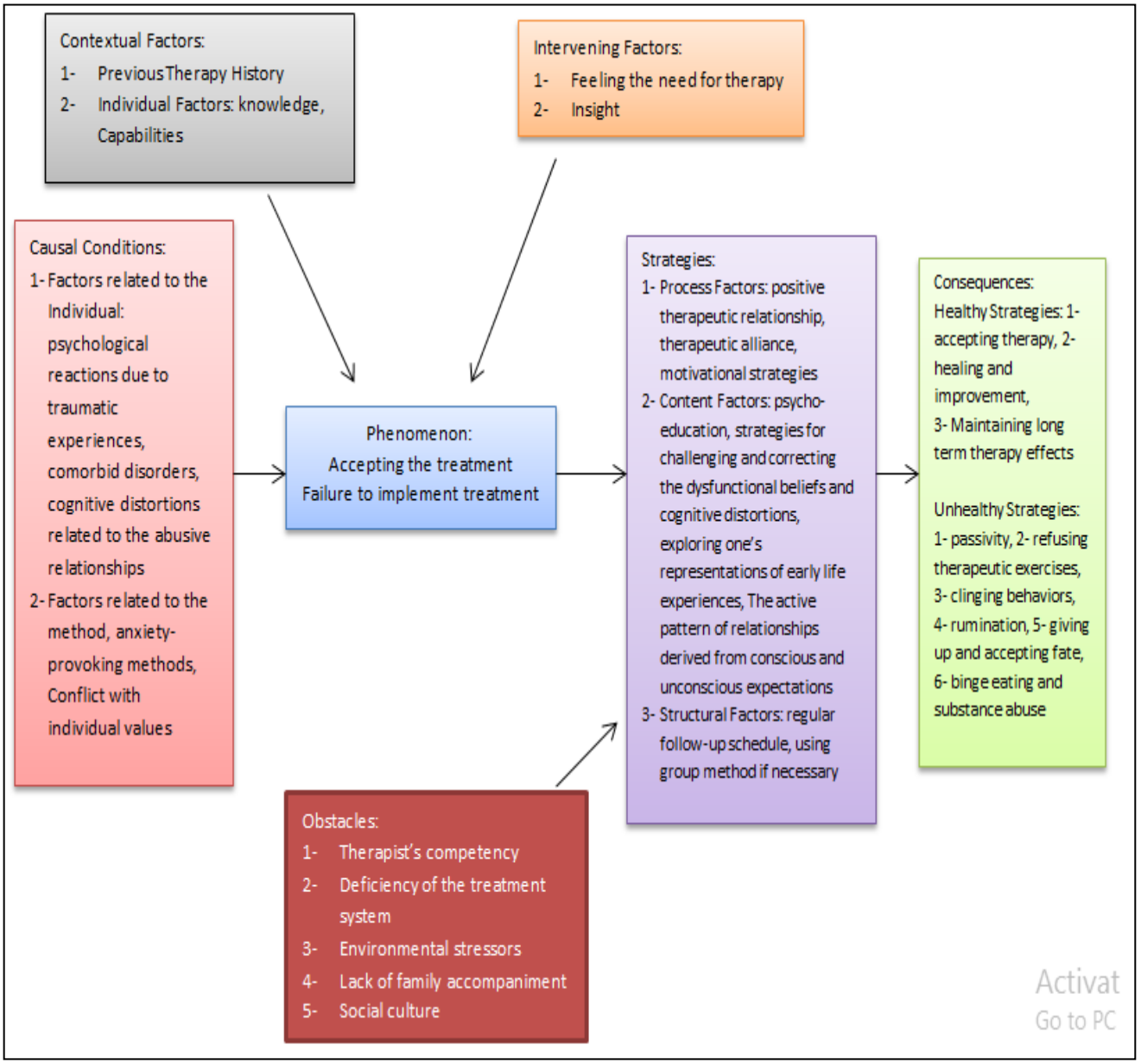

Figure 2. Axial Paradigm Model Depicting Factors Influencing Acceptance and Implementation of Treatment in Individuals with a History of Abusive Relationships

Findings of the Second Stage:

Participants' Characteristics

The flowchart of the participants through the trial is depicted in Figure 3. A total of 36 participants were screened and 24 subjects underwent randomization. Of these, posttest data were available for all the participants to be included in the intention-to-treat analysis (Figure 3). Table 2 shows the demographic characteristics of the participants. The mean age of the participants was 26.58 (SD = 6.21) years. Of the participants, 83.3% were female, 66.7% were single, 75.0% had university education, 58.3% were employed, 50.0 were cigarette smoker, 20.8% consumed opium, and 83.3% had a history of visiting a psychiatrist. Demographic characteristics were well balanced between control and intervention groups (see Table 2). Based on the demographic variable information, most of the participants were women, since there were 10 women and two men in both intervention and control groups equally. Additionally, most of them had a bachelor's degree, were single, and had a history of visiting a psychiatrist. It should be noted that to control intervening variables, the intervention and control groups were homogenized in terms of education, employment, smoking history, and history of psychiatric medications.

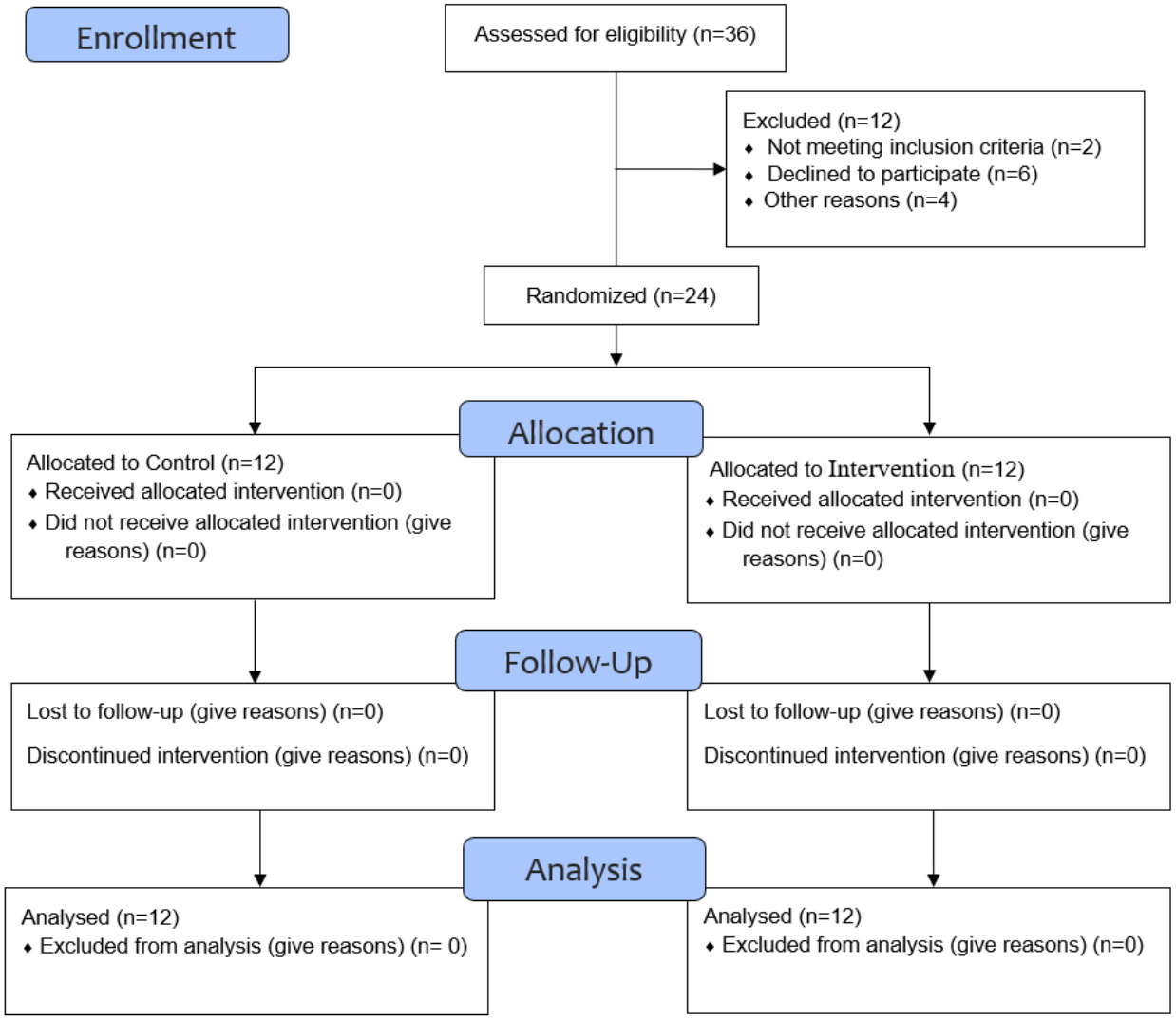

Figure 3. The CONSORT Flow Diagram -The Progress of Study Participants through each Stage of a Randomized Controlled Trial

Table 2. Socio-Demographic Characteristics of the Participants

	Total (n = 24)	Group	
		Control (n = 12)	Intervention (n = 12)
Age (years), mean (SD)	26.58 (6.21)	27.25 (6.21)	25.92 (6.40)
Gender, n (%)			
Male	4 (16.7)	2 (16.7)	2 (16.7)
Female	20 (83.3)	10 (83.3)	10 (83.3)
Marital status, n (%)			
Single	16 (66.7)	9 (75.0)	7 (58.3)
Married	3 (12.5)	1 (8.3)	2 (16.7)

Divorced	5 (20.8)	2 (16.7)	3 (25.0)
Level of education, n (%)			
Secondary	6 (25.0)	3 (25.0)	3 (25.0)
University	18 (75.0)	9 (75.0)	9 (75.0)
Employment, n (%)			
Employed	14 (58.3)	7 (58.3)	7 (58.3)
Unemployed	10 (41.7)	5 (41.7)	5 (41.7)
Cigarette smoking	12 (50.0)	4 (33.3)	8 (66.7)
Opium consumption	5 (20.8)	1 (8.3)	4 (33.3)
History of visiting a psychiatrist	20 (83.3)	10 (83.3)	10 (83.3)

SD: Standard Deviation.

Primary Outcomes

Since all the assumptions of ANCOVA were met, ANCOVA was used to compare control and intervention groups. After adjusting for pretest scores, the participants in the intervention group scored, on average, 53.4 (95% CI: 34.6 to 72.1) points lower on the TREARS score than the participants in the control group at the posttest measurement ($F_{(1, 22)} = 15.38$, $P < 0.001$, $\eta^2_P = 0.411$). The effect size, calculated using partial eta squared, was 0.411, which is considered to be large (Table 3, Figure 4).

Table 3. Results of ANCOVA Examining the Effect of Intervention on the Tendency to Re-Experiencing Abusive Relationships Score

	Control (n = 12)	Intervention (n = 12)	Adjusted mean Difference (95% CI)[a]	$F_{(1, 22)}$	*P*	η^2_p
TREARS score						
Pretest	187.3 (15.6)	206.5 (16.1)				
Posttest	193.5 (24.4)	153.3 (25.7)	-53.4 (-72.1 to -34.6)	15.38	< 0.001	0.411

CI: Confidence Interval; TREARS: Tendency to Re-Experiencing Abusive Relationships Scale. Data are mean (SD), unless otherwise specified. [a]Adjusted for pretest scores. η^2_p values of 0.01-0.06, 0.06-0.14, and > 0.14 were considered small, medium, and large effect sizes, respectively.

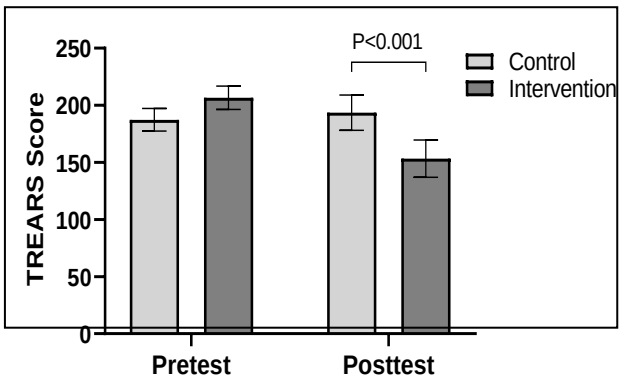

Figure 4. Comparison of Tendency to Re-Experiencing Abusive Relationships Scores During the Intervention in the Control and Intervention Groups

TREARS: Tendency to Re-Experiencing Abusive Relationships Scale. Data are mean and 95% confidence interval (95% CI). P-value is based on ANCOVA adjusted for pretest scores.

Discussion

This pilot study highlights the potential of a transdiagnostic, factor-based intervention to interrupt the cycle of re-experiencing abusive relationships. By conducting content analysis, the main components in developing the factor-based transdiagnostic educational package emerged. These findings showed that the intervention package, in its procedural, structural, and content dimensions, should incorporate elements and strategies that are more person-centered rather than rule-centered. In other words, treatment processes and strategies should be tailored to the needs of the individuals. As in the three-layer model of psychotherapy and personality, changes in behavior can lead to changes in conscious perceptions and can also result in changes in the structure of unconscious representations of events. Indeed, changes in each layer can lead to changes in other layers, and thus, relational and cultural influences on the individual can be encompassed. The current research has considered changes in all three layers without any diagnostic labels.

As seen in the current treatment package, the three functional layers—behavior, conscious experience (cognition and perception), and unconscious experience (psychodynamics)—are addressed through the integration of techniques from short-term psychodynamic theories, cognitive and emotional schema therapy, and Acceptance and Commitment Therapy (ACT) approaches, facilitating healing across all three layers.

The findings of the secondary purpose of the present study show that the factor-based transdiagnostic therapy was significantly effective in preventing the re-experiencing of abusive relationships in the subjects of the experimental group. The findings showed that there is a significant difference between the scores of the tendency to re-experience abusive relationships in the experimental and the control groups.

Despite limited research in this area, the result of this research is aligned with the research of Hugo (2018) in some aspects, including the application of an integrative therapeutic approach in improving the well-being of women survivors of domestic violence. The results of Hugo's research conducted on female survivors of domestic violence at the University of Mississippi showed that the effectiveness of integrating Narrative Therapy and Acceptance and Commitment Therapy in a therapy package to resolve trauma and break the cycle of abuse to help victims of domestic violence was significant (7). The present study, in comparison to the mentioned research, has not only utilized cognitive and postmodern approaches but also incorporated contextual approaches. The findings of the present study are also in line with the findings of the following researchers: Flasch and colleagues (2015) regarding key factors in the process of recovery and planning for supportive treatments of survivors of violence (36), and Daneshmandi (2013) concerning the effectiveness of the emotional schema therapy on emotional regulation, communication skills and emotional schemas in female victims of child abuse and neglect (37).

Furthermore, the results of a study conducted by Flasch and his colleagues (2015) showed that educating the survivors about abusive relationships and examining them as well as determining how to enter into new intimate relationships facilitate the improvement of mental health symptoms and restoring values and personal identity as well as the healing process and the experience of a life without violence in them (36). The study conducted by Cridade and colleagues (2020) also highlights that interventions addressing issues stemming from abusive relationships are advantageous in two ways: first, increasing awareness, developing skills to establish healthy relationships, and second, identifying available resources and using support networks. These strategies are particularly effective in mitigating problems influenced by dominant value systems, social norms, behavioral models, and cognitive distortions (38).

It seems that the therapy package is able to create significant effectiveness in the intervention group because it is localized based on the thematic model resulting from re-experiencing abusive relationships in several characteristics under the contextual conditions, causal conditions, maintaining factors, strategies and consequences, and intervening factors (9). In explaining the effectiveness of the present therapy, the following points can be mentioned.

At first, with short-term psychodynamic and object relations therapy with conflict triangles and the person, by creating a warm and non-judgmental therapeutic relationship, clients received enough knowledge about themselves to know what factors affected their existing problems and how. By reflecting on the issues related to the family of origin, clients find their role in their current problems and gain new insights into their unconscious thoughts and emotions. By linking impulse, defense, and anxiety, as well as by interpreting the person's triangle, establishing useful links between their past and the transition in the present, the researchers interpreted the conflicts so that the clients could face their fears and reduce the need for further defenses. Then by employing techniques of cognitive schemas and schema modes, this therapy package helped the victims of abusive relationships to identify and improve maladaptive schemas and schema modes, such as the vulnerable defective child, impulsive child, and the ineffective or demanding parent. Through addressing surrender and avoidance coping styles, the intervention aimed to strengthen the healthy adult mode. It also encouraged the participants to externalize the internalized ineffective parent, thereby not only achieving the goal of distancing the problem from the self, but also resolving internal conflicts related to decision-making and liberating themselves from the abusive relationship. ACT certainly enhanced therapy seekers' acceptance and believability of the treatment with its pure metaphors and parables. At the end, with the therapists' help, the clients evaluated the emotions and their control strategies in the development and continuation of the abuse using emotional schema therapy techniques. It seems that psychodynamic theory techniques at the level of unconscious experience, schema therapy cognitive and emotional at the level of conscious experience, and ACT at the behavioral level have collectively contributed to the effectiveness of the treatment package.

The turning point in the effectiveness of the present treatment is that during this treatment, the client overcame the cycle of repetition of abusive relationships by using the main therapeutic techniques in a transdiagnostic protocol free from any diagnostic label. One of the innovative aspects of the present treatment is that it is provided by the eclecticism of therapeutic techniques that are appropriate to what the client needs to stop the repetitive cycle of abusive relationships. In fact, this treatment has been effective in the intervention group by examining people's experiences and

influencing the understanding of the repetitive ways of some destructive behaviors, helping the person to overcome the tendency to suppress or ignore feelings, strengthening and training in order to fix poor communication skills and create opportunities to learn appropriate coping skills. These skills include problem-solving, compromising, resolving conflicts, taking personal responsibility, and decision-making, strengthening self-esteem, and overcoming shame by creating a sense of power and control over life and overcoming feelings of inadequacy, unrealistic expectations and beliefs. In addition, addressing self-destructive behaviors, such as unhealthy coping strategies, substance abuse, and suicidal attempts, contributed to the effectiveness of this treatment.

Limitation

One limitation of the current research was holding therapy sessions individually due to the Covid-19 pandemic, and also the lack of follow-up. Therefore, we suggest that follow-up be included in future research. Since group therapy might be more beneficial, it is also suggested that research be conducted in group setting. Moreover, we hope that treatment for abusive relationships can help prevent the damage caused by divorce and child custody issues. Thus, we suggest that the effectiveness of the therapy be investigated in couple samples as well.

Conclusion

The results of the present study demonstrate the effectiveness of the factor-based transdiagnostic package on the prevention of re-experiencing abusive relationships. It seems that the present interventions, through its multifaceted nature and adaptation to the needs of survivors, can reduce the likelihood of re-experiencing abusive relationships. These results have important implications for therapeutic interventions, particularly in psychological clinics, where they can inform strategies to prevent individuals from repeating the cycle of abusive relationships. Additionally, these interventions can be applied in educational sessions and workshops for adolescents in high schools and universities.

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Conflict of Interest

None.

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