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Comparison of the Effectiveness of Unified Transdiagnostic Treatment and Compassion-Based Approach on Suicidal Ideation and Spiritual Well-Being in Women Victims of Domestic Violence

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A B S T R A C T

Objective: The present study aimed to compare the effectiveness of Unified Transdiagnostic Treatment and the Compassion-Based Approach on suicidal ideation and spiritual well-being in women victims of domestic violence.

Methods: This study is applied in terms of its purpose and quasi-experimental in nature and method, utilizing a pre-test, post-test, and two-month follow-up design with a control group. The study population comprised all women victims of domestic violence who sought help from social emergency centers and family counseling clinics in Tehran during the second half of 2023. The sample consisted of 51 participants who were selected through purposive sampling and randomly assigned to experimental and control groups. The first experimental group received an eight-session (90-minute each) Compassion-Based Therapy intervention program, while the second experimental group received a ten-session (60-minute each) Unified Transdiagnostic Treatment program at these centers. The control group did not receive any intervention. Data collection tools included the Violence Against Women Questionnaire by Haj-Yahya (2001), the Beck and Steer Suicidal Ideation Scale (1991), and the Spiritual Well-Being Scale by Paloutzian and Ellison (1982). The obtained data were analyzed using repeated measures analysis of covariance (ANCOVA) and Bonferroni post hoc test with SPSS 27 software.

Findings: The study findings indicate that both Compassion-Based Therapy and Unified Transdiagnostic Treatment led to a reduction in suicidal ideation and an increase in spiritual well-being in the experimental groups. Additionally, considering the mean difference, Unified Transdiagnostic Treatment had a greater effect than the Compassion-Based Approach in reducing suicidal ideation and enhancing spiritual well-being ($p < .05$).

Conclusion: Based on the findings of this study, Compassion-Based Therapy and Unified Transdiagnostic Treatment are effective approaches for improving spirituality and reducing suicidal ideation in women victims of domestic violence. Psychologists and family specialists are encouraged to utilize these findings to enhance the quality of family life.

Keywords: *Compassion-Based Therapy, Unified Transdiagnostic Treatment, Suicidal Ideation, Spiritual Well-Being, Domestic Violence.*

1. Introduction

Domestic violence against women is a major mental health issue and the most common form of violence experienced by women, encompassing physical, sexual, emotional abuse, and controlling behaviors by an intimate partner (Erez et al., 2024; Hertanto et al., 2024). Estimates of the prevalence of domestic violence against women vary significantly depending on the definitions used (Kadhim, 2024; Kobrlo, 2024; Muchtarom, 2024). Worldwide, women have experienced physical or sexual violence by a current or former intimate partner. Domestic violence among victims is associated with a wide range of serious health consequences, such as physical injuries, terminated pregnancies, sexually transmitted diseases, post-traumatic stress disorder, depression, and suicide (Devkota Sapkota & Simkhada, 2024). Therefore, one of the potential risk factors for perpetrating domestic violence against women may be psychiatric disorders, and the causal links might differ across various disorders. Common deficits associated with mental disorders, such as poor interpersonal skills and emotional dysregulation (Kadhim, 2024; Thamizhmathi et al., 2024), as well as specific core symptoms of certain disorders like impulsivity (seen in individuals with attention-deficit/hyperactivity disorder and substance use disorders) (Kadhim, 2024), may contribute. Furthermore, the hostility displayed in some individuals with mood disorders and antisocial personality disorder (Spencer et al., 2019) is linked to domestic violence against women. Research in Iran on the issue of domestic violence against women has reported various statistics on the rates of physical and sexual abuse; however, a common thread across most studies is that over 60 percent of women experience violence perpetrated by their spouses. National findings indicate that 66 percent of Iranian women, from the start of their married lives up to the time of the research, have experienced violence at least once, with the most prevalent type being psychological and verbal violence (52.7 percent). In Iran, the prevalence of domestic violence ranges from 59 percent in the central regions to 75 percent in the western parts of the country (Golmohammad et al., 2021). All of this underscores that violence against women is the most common crime worldwide with the least punishment.

The occurrence of psychological, emotional, and physical harm within families, such as domestic violence, also increases suicidal thoughts among victims, thereby elevating the risk of suicide (Jabbari & Aghili, 2023). Suicide is a serious global public health problem, and its occurrence not only causes immense grief to each family but also has a significant negative impact on society and may escalate economic burdens and health problems (Adams & van Dahlen, 2021). Suicide is the eleventh leading cause of death for all ages in the United States, the second leading cause of death for those aged 10 to 34 years, and the fifth leading cause of death for those aged 35 to 44 years. Every second, someone attempts suicide, and every 40 seconds, someone dies by suicide (Anisi et al., 2022). Suicide and suicidal behavior (including ideation, planning, and attempts) represent significant and noteworthy issues. Suicidal ideation should be considered a warning sign that requires clinical attention, as some patients with such thoughts may progress to suicidal behavior (Campisi et al., 2020; Haji Heidari & Sajadian, 2023). A history of severe mood disorders, including depression and psychotic disorders, as well as impulsive behaviors and borderline personality disorder, considerably heightens the risk of attempted suicide and suicidal thoughts (Anisi et al., 2022; Nur, 2023). Moreover, feelings of depression and regret over past actions substantially increase suicidal ideation (Mars et al., 2018). The World Health Organization (2022) considers the causes of suicide to be very complex and diverse, falling into five categories: psychological, biological, cultural, social, and environmental. Several dangerous factors for suicidal ideation and behavior exist, including a history of suicidal behaviors, the presence of psychiatric disorders—especially mood disorders and personality disorders—along with temperamental and psychological components (Haji Heidari & Sajadian, 2023). Research shows that suicidal behaviors are common among individuals who have experienced domestic violence, and exposure to domestic violence has a direct correlation with suicide resilience (Asadi Hasanvand et al., 2022). In fact, due to severe domestic violence, victims may sustain physical injuries and, under the psychological pressure stemming from abuse, engage in passive reactions such as suicide or pseudo-suicide (Campisi et al., 2020)..

The use of religious beliefs and spirituality is often regarded as a constructive coping strategy to reduce the harms associated with domestic violence among women (Agarwal et al., 2020). The World Health Organization includes physical, psychological, social, and spiritual dimensions in defining human existence (Pirutinsky et al., 2020). Spiritual well-being is the newest dimension of health, alongside the other dimensions of health such as physical, mental, and social well-being. Some believe that without spiritual well-being, attaining a high quality of life is not possible (Agarwal et al., 2020; Chenari &

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Kazemizadeh, 2017). Spiritual well-being is a multidimensional concept that encompasses pain and death, guilt and shame, reconciliation and forgiveness, freedom and responsibility, hope and despair, as well as love and joy (Sheyvandi Chelicheh et al., 2023; Tamjidfar, 2022). The World Health Organization states that, beyond mental, physical, and social health, spiritual well-being is one of the four pillars of an individual's overall health (Magnano et al., 2019). Research indicates that higher levels of spiritual well-being reduce attitudes toward violence (Haji Heidari & Sajadian, 2023; Hosseini Akhgar et al., 2018)) and lower physical and sexual aggression (Michaelson et al., 2016; Plante, 2018; Sheyvandi Chelicheh et al., 2023).

To improve the psychological, emotional, and relational components of women victims of domestic violence, various therapeutic and educational methods have been employed. Among the newer educational approaches is Barlow's Unified Transdiagnostic Treatment and its final version, Unified Protocol for Transdiagnostic Treatment (Steele et al., 2018). This protocol was designed to target shared and transdiagnostic causal factors and is intended for individuals with anxiety and unipolar mood disorders, with potential applicability to other emotional and psychological disorders. The results of various studies (Liu et al., 2019; Norton & Paulus, 2016; Steele et al., 2018) indicate that the Unified Transdiagnostic Treatment effectively improves psychological, emotional, and relational components in different populations. Although the Unified Transdiagnostic Treatment stems from cognitive-behavioral therapy, it places emphasis on emotions and maladaptive emotion regulation strategies. Emotional experiences and responses to emotions form the core foundation in the transdiagnostic approach (Liu et al., 2019). The primary goal of the Unified Transdiagnostic Treatment is for clients to develop skills that enable them to effectively manage negative emotions. This treatment teaches individuals how to confront their disruptive emotions and respond to environmental triggers in more adaptive ways. By changing dysfunctional emotional self-regulation habits, the frequency and intensity of maladaptive emotional habits are decreased, ultimately reducing distress and enhancing social, relational, behavioral, and psychological functioning (Steele et al., 2018).

Another therapeutic method used to improve the psychological components in women victims of domestic violence is Compassion-Based Therapy, first developed and formulated by Paul Gilbert in the early 21st century. Neff (2003) described self-compassion as comprising three components: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. Gilbert (2009) introduced this construct in therapeutic settings, ultimately establishing Compassion-Focused Therapy. The foundational principles of Compassion-Focused Therapy suggest that external soothing thoughts, factors, imagery, and behaviors must be internalized so that the human mind responds to these internal elements just as it reacts to external ones, leading to a calming effect (Gilbert, 2009a, 2009b, 2010, 2014, 2015; Gilbert, 2018; Gilbert et al., 2022). Additionally, Compassion-Focused Therapy teaches individuals not to avoid or suppress painful emotions. Instead, they learn to recognize their experiences and approach these experiences with compassion (Gilbert et al., 2022). Besides protecting individuals against negative psychological states, self-compassion fosters positive emotional states.

In Iran, and specifically in Tehran, for several years both the public consciousness and the concerns expressed by community leaders have pointed to a crisis within families and marital life. While marriage rates are not particularly low, domestic violence has been on the rise. Moreover, women's visits to counseling centers and their statements notably point to crises in their relationships with others, even in ostensibly stable marriages. Given the severe detrimental effects of domestic violence on women in various individual, familial, psychological, and social dimensions, the necessity of a deeper exploration of this issue—taking into account the specific sensitivities of these women—is evident. Accordingly, this study seeks to gain a better, more precise understanding of the psychological problems faced by women under domestic violence. On the one hand, the transdiagnostic approach places special emphasis on emotion regulation and aims to help clients learn how to experience and respond to unpleasant emotions in more adaptive, non-avoidant ways (Sakiris & Berle, 2019). Rather than eliminating emotions, it focuses on recognizing, tolerating, and coping with negative emotions. This approach facilitates the identification of thought processes affecting emotions and behaviors that generate negative emotions, enabling individuals to learn to increase their tolerance of these emotions (Steel et al., 2018).

In Compassion-Based Therapy, as in the unified transdiagnostic approach, the goal is not to eliminate or replace negative emotions with positive ones. Instead, Compassion-Based Therapy generates positive emotions that coexist with negative ones, better equipping individuals with acceptance and understanding to confront life's

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challenges (Sanagouye Moharer et al., 2020; Tamjidfar, 2022). Consequently, they can manage adversity effectively and endure life's difficulties.

Therefore, the present study aimed to compare the effectiveness of a Compassion-Based Approach versus a Unified Transdiagnostic Intervention for women victims of domestic violence. An examination of existing research in Iran shows that despite the numerous applications and benefits of the Unified Transdiagnostic Intervention and Compassion-Based Therapy, no study has yet compared these approaches in this context. Hence, the primary innovation of this research lies in investigating these two interventions within this particular population. Consequently, the fundamental question of this study is: "Is there a difference between Unified Transdiagnostic Treatment and the Compassion-Based Approach in terms of their effects on suicidal ideation and spiritual well-being among women victims of domestic violence?"

2. Methods and Materials

This study was applied in terms of its objective and quasi-experimental in nature and method, employing a pre-test, post-test, and two-month follow-up design with a control group. The statistical population consisted of all women victims of domestic violence in Tehran who sought help from social emergency centers and family counseling clinics (Farahbakhsh Clinic, Narvan Clinic, and Tehran University West Clinic) in the second half of 2023. The sample was selected using purposive sampling. Women victims of domestic violence were identified by visiting these social emergency centers and family counseling clinics in Tehran. The initial sample included 300 women, from whom 64 individuals were selected based on scores higher than the mean on the Haj-Yahya Domestic Violence Questionnaire (2001).

The sample size was determined using G*Power software. Considering an alpha of 0.05, a statistical power of 0.80, and an effect size of 0.50, the required sample size was calculated to be 15 participants per group. To account for possible attrition, 18 participants were included in each group, totaling 54 participants, based on inclusion and exclusion criteria.

The inclusion criteria were a score above the mean (64) on the Haj-Yahya Domestic Violence Questionnaire (2001), age between 25 and 50 years, a minimum of one year of cohabitation in a marital relationship, no history of psychiatric disorders or specific physical illnesses (as verified by medical records), willingness to participate in the study (after receiving detailed information about the research objectives, an informed consent form was obtained), and commitment to attending the intervention sessions.

The exclusion criteria were withdrawal from participation, refusal to complete the questionnaires, and absence from more than two intervention sessions.

2.1. Data Collection Tools

The Haj-Yahya Domestic Violence Against Women Questionnaire (2001) was used to assess domestic violence. This questionnaire consists of 32 items across four subscales: psychological violence (items 1–16), physical violence (items 17–27), sexual violence (items 28–30), and economic violence (items 31–32). Responses are scored on a scale from 1 (Never) to 3 (Twice or more). The questionnaire was translated into Persian by Khaghani-Far at Al-Zahra University, and its validity was confirmed by several experts. The internal consistency coefficient (Cronbach's alpha) was reported as 0.97 in a sample of 460 participants. A large-scale study conducted among 2,410 Palestinian women reported Cronbach's alpha values of 0.71, 0.86, 0.92, and 0.93 for the four subscales, respectively. Golmohammadi et al. (2021) reported an overall reliability of 0.89 using Cronbach's alpha. In the present study, the reliability coefficient using Cronbach's alpha was 0.88 (Golmohammad et al., 2021).

The Beck and Steer Suicidal Ideation Scale (1991) was used to assess suicidal ideation. This 19-item self-report tool measures the intensity of suicidal thoughts, behaviors, and planning. Each item is scored on a three-point scale (0–2), with a total score ranging from 0 to 38. The scale evaluates factors such as the desire for death, active and passive suicidal tendencies, duration and frequency of suicidal thoughts, perceived control over oneself, protective factors against suicide, and readiness to act on suicidal intentions. The scale includes five screening items, and if a participant indicates any suicidal intent, they must complete the remaining 14 items. The average completion time is 10 minutes. Scoring categories are 0–5 for no suicidal ideation, 6–9 for the presence of suicidal thoughts, and 20–38 for a high risk of suicide attempt. Beck and Steer (1991) reported internal consistency (Cronbach's alpha) between 0.89–0.96 and concurrent validity of 0.83, with significant correlations with the Beck Depression Inventory and the Hopelessness Scale. In Iran, Anisi et al. (2005) validated the scale,

reporting a Cronbach's alpha of 0.95 and concurrent validity of 0.76 with the General Health Questionnaire's depression subscale. In the present study, Cronbach's alpha was 0.79 (Anisi et al., 2022).

To assess spiritual well-being, the Paloutzian and Ellison Spiritual Well-Being Scale (1982) was used. This 20-item scale includes two subscales: religious well-being and existential well-being. Responses are measured on a six-point Likert scale from "Strongly Disagree" to "Strongly Agree," with scores ranging from 20 to 120. Higher scores indicate greater religious and existential well-being. Paloutzian and Ellison (1982) reported an overall Cronbach's alpha of 0.93. In Iran, Seyyed Fatemi et al. (2006) validated the scale, reporting a Cronbach's alpha of 0.82 (Tamjidfar, 2022). In the present study, Cronbach's alpha for the total scale was 0.85.

2.2. Interventions

2.2.1. Compassion-Based Therapy (CFT)

In the first session, participants are introduced to each other, and the overall structure of the program is explained, including the number and duration of sessions, group rules, and expectations. A brief introduction to Compassion-Focused Therapy (CFT) and its core principles is provided. Participants practice rhythmic soothing breathing as a relaxation technique. The session concludes with a pre-test assessment.

In the second session, participants review their homework and reflect on their self-criticism patterns. The therapist explains the concept of self-criticism, its causes, and its consequences. Participants are introduced to the three emotional regulation systems (threat, drive, and soothing) and how they interact. Compassion is defined and discussed as an approach to balancing these systems. Participants practice rhythmic breathing and identify their self-critical thoughts and behaviors.

In the third session, participants learn about the benefits of self-compassion and self-kindness through self-care. The session starts with a review of the previous session and homework. The therapist explains the characteristics and skills of self-compassion and how it influences emotional well-being. Mindfulness as a fundamental practice in self-compassion is introduced. Participants discuss how they react in difficult situations and engage in mindful breathing exercises. They are assigned the task of reflecting on the degree of compassion they show themselves.

In the fourth session, the focus is on finding the role of compassion in life, managing anger, and cultivating understanding and gentleness toward oneself and others. Participants engage in a yoga relaxation exercise to manage anxiety and impulsivity. Guided imagery is introduced as a technique to cultivate a compassionate mindset. The therapist assesses the participants' levels of impulsivity in different situations and teaches them how to use yoga exercises for emotional regulation. A compassionate imagery exercise is conducted to reinforce these skills. Participants complete a worksheet on compassion skills.

In the fifth session, participants explore shared human experiences and managing difficult emotions. The therapist introduces the concepts of wisdom, strength, warmth, and responsibility in fostering compassion. Participants engage in a written exercise where they compose a compassionate letter to themselves, incorporating these elements. A breathing exercise incorporating wisdom, strength, and warmth is practiced. Participants are tasked with writing a compassionate letter as homework.

In the sixth session, participants explore their core values. The session begins with a review of the previous assignment, in which participants complete the second part of their compassionate letter. The therapist introduces the concept of awareness and its rationale, teaching participants how to cultivate meaningful emotions and take responsibility for their compassionate mindset. The session concludes with a compassionate body scan exercise. Participants are assigned additional practice exercises.

In the seventh session, the focus is on recognizing conflicting emotions, healing psychological wounds, and enhancing self-empowerment. Participants reflect on their self-compassion journey, identifying the various dimensions of compassionate thinking, emotions, and behaviors. The therapist discusses how self-compassion influences anger, anxiety, and other emotional reactions. Participants practice mindful eating using a raisin to develop present-moment awareness. They are assigned a self-compassion imagery exercise.

In the eighth session, the educational content of previous sessions is reviewed. Participants reflect on the role of compassion in emotional regulation and cognitive processing. The therapist reinforces the contrast between compassionate and critical thinking styles. Interpersonal sensitivity and rejection-related responses are discussed, and participants practice applying compassion skills to manage these reactions. The session concludes with a personalized self-compassion mantra exercise and the post-test

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assessment. Participants are encouraged to continue practicing the techniques in their daily lives.

2.2.2. *Unified Transdiagnostic Treatment (UTT)*

In the first session, participants are guided in clarifying their core values. The therapist explains the concept of values and helps participants identify their most important personal values. Participants engage in exercises designed to help them align their behaviors with these values. As homework, they identify and implement behavioral plans in accordance with their values.

In the second session, participants focus on increasing awareness of emotions without judgment. Mindfulness exercises are introduced to help participants remain present and accept their experiences without avoidance. Participants practice mindfulness techniques throughout the week as part of their assignments.

In the third session, the therapist helps participants reduce negative evaluations and neutralize distressing thoughts through cognitive defusion. Participants are introduced to the concept of cognitive defusion, which helps them distance themselves from unhelpful thoughts. They practice exercises designed to create psychological separation from distressing thoughts. Cognitive defusion techniques are assigned for practice during the week.

In the fourth session, cognitive flexibility is expanded. The therapist conducts exercises to help participants develop alternative perspectives and enhance their flexibility in interpreting reality. Participants learn to examine situations from multiple angles and generate alternative explanations. Homework includes practicing cognitive flexibility and identifying alternative interpretations for real-life situations.

In the fifth session, participants focus on self-soothing and relaxation techniques. The session includes a review of previous assignments and the development of an individualized relaxation and self-soothing plan. Participants practice self-soothing strategies to reduce distress. They are assigned relaxation exercises to practice throughout the week.

In the sixth session, participants work on reducing experiential avoidance by engaging in behaviors that counteract their habitual avoidance tendencies. The therapist introduces the concept of opposite action, encouraging participants to engage in behaviors that contrast with their emotional urges. Participants practice confronting rather than avoiding their emotions throughout the week.

In the seventh session, the importance of interpersonal relationships is addressed. Participants engage in exercises to enhance interpersonal effectiveness, such as mindful listening and assertive communication. The therapist helps participants understand the role of effective communication in emotional well-being. Participants practice interpersonal communication skills throughout the week.

In the eighth session, participants work on reducing fear of negative emotions and increasing emotional tolerance. The therapist guides them in exposure-based imagery exercises where they visualize distressing emotions in a controlled manner. This helps participants reduce avoidance behaviors and build resilience. Homework includes imagery-based exposure exercises.

In the ninth session, participants are encouraged to become more accustomed to painful emotions and reduce avoidance tendencies. The session focuses on real-life exposure to distressing bodily sensations associated with emotions. Participants gradually face uncomfortable physical sensations to build tolerance. They practice bodily exposure exercises throughout the week.

In the tenth session, participants engage in desensitization exercises for distressing experiences. They undergo situational exposure, progressing through a structured hierarchy of feared situations. Participants practice confronting distressing experiences at least three or four times as part of their final assignment. The session concludes with a post-test assessment.

2.3. *Procedure*

Following ethical approvals and authorization, coordination was made with the Tehran Welfare Organization to access social emergency centers and family counseling clinics. A total of 300 women victims of domestic violence who visited Farahbakhsh Clinic, Narvan Clinic, and Tehran University West Clinic in the second half of 2023 were randomly selected from medical records. They were invited to participate in the study through an online questionnaire that included demographic questions, the Haj-Yahya Domestic Violence Questionnaire (2001), the Beck and Steer Suicidal Ideation Scale (1991), and the Paloutzian and Ellison Spiritual Well-Being Scale (1982).

From this initial group, 54 participants who scored above the mean (64) on the Domestic Violence Questionnaire were purposively selected. Participants were matched for age, marital life duration, education level, and living conditions

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using Chi-square tests. They were then randomly assigned to one of three groups: Experimental Group 1 (Compassion-Based Therapy; 18 participants), Experimental Group 2 (Unified Transdiagnostic Treatment; 18 participants), and Control Group (No intervention; 18 participants).

After the pre-test, intervention sessions were conducted at social emergency centers and counseling clinics. Experimental Group 1 received eight 90-minute sessions of Compassion-Based Therapy, following the protocol developed by Neff (2003). Experimental Group 2 received ten 60-minute sessions of Unified Transdiagnostic Treatment, based on the protocol developed by McKay et al. (2011) (translated by Foroughi & Sa'ad, 2017). The Control Group received no intervention. Both intervention programs were conducted in a group format, with participants gathering at a designated center for treatment.

Following the intervention sessions, all groups completed the post-test under identical conditions. A two-month follow-up assessment was conducted, where participants completed the same questionnaires to assess the stability of the interventions' effects. During this period, the control group received no intervention.

Due to participant dropout, the final sample analyzed included 51 individuals: Control Group (16 participants), Compassion-Based Therapy Group (18 participants), and Unified Transdiagnostic Treatment Group (17 participants).

2.4. Data Analysis

The collected data were analyzed using repeated measures ANCOVA and Bonferroni post hoc tests. All statistical analyses were conducted using SPSS 27.

3. Findings and Results

In this study, 51 women victims of domestic violence in Tehran participated. They were assigned to three groups: the Unified Transdiagnostic group (17 participants), the Compassion-Based Approach group (18 participants), and the Control group (16 participants). Their mean ages were 32.94±7.85, 32.83±8.13, and 31.94±6.13 years, respectively, in an age range of 25 to 47 years.

Table 1

Descriptive Statistics (Variable, Group, Stage, Mean, SD, Shapiro-Wilk Statistic, Significance Level)

Variable	Group	Stage	Mean	SD	Shapiro-Wilk Statistic	Significance Level
Suicidal Ideation	Unified Transdiagnostic	Pre-test	11.59	2.35	0.95	0.430
		Post-test	6.65	2.42	0.93	0.217
		Follow-up	7.88	2.52	0.93	0.247
	Compassion-Based	Pre-test	12.83	3.17	0.89	0.059
		Post-test	8.39	2.43	0.95	0.353
		Follow-up	9.78	2.18	0.91	0.101
	Control	Pre-test	12.75	3.26	0.93	0.227
		Post-test	11.81	2.46	0.95	0.416
		Follow-up	12.13	1.78	0.95	0.420
Religious Well-Being	Unified Transdiagnostic	Pre-test	22.53	2.69	0.97	0.793
		Post-test	32.41	3.79	0.97	0.769
		Follow-up	31.29	3.92	0.96	0.614
	Compassion-Based	Pre-test	23.33	3.94	0.96	0.660
		Post-test	28.72	4.55	0.95	0.470
		Follow-up	27.17	5.17	0.95	0.405
	Control	Pre-test	23.25	4.82	0.89	0.060
		Post-test	24.13	4.86	0.90	0.074
		Follow-up	23.62	4.84	0.91	0.126
Existential Well-Being	Unified Transdiagnostic	Pre-test	23.94	3.96	0.88	0.038
		Post-test	34.29	3.58	0.97	0.806
		Follow-up	31.47	3.94	0.93	0.205
	Compassion-Based	Pre-test	23.56	5.19	0.96	0.667
		Post-test	29.17	3.11	0.94	0.245
		Follow-up	27.72	3.03	0.93	0.189
	Control	Pre-test	24.19	5.28	0.90	0.072
		Post-test	24.87	5.81	0.88	0.052
		Follow-up	23.94	5.28	0.91	0.119
Total Spiritual Well-Being	Unified Transdiagnostic	Pre-test	46.47	5.87	0.97	0.852

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		Post-test	66.71	5.78	0.96	0.579
		Follow-up	62.76	5.82	0.96	0.583
	Compassion-Based	Pre-test	46.89	8.46	0.97	0.772
		Post-test	57.89	6.72	0.95	0.403
		Follow-up	54.88	7.25	0.97	0.756
	Control	Pre-test	47.44	9.87	0.93	0.185
		Post-test	48.06	10.01	0.94	0.334
		Follow-up	47.81	10.36	0.92	0.162

Table 1 presents the descriptive statistics (mean and standard deviation) for suicidal ideation and spiritual well-being across the three groups (Unified Transdiagnostic, Compassion-Based Approach, and Control) at the pre-test, post-test, and follow-up stages. As shown, in the Control group, both suicidal ideation and spiritual well-being scores did not change appreciably from pre-test to post-test. However, in both experimental groups, suicidal ideation decreased and spiritual well-being increased in the post-test compared to the pre-test. For each variable, the Shapiro-Wilk statistic was nonsignificant ($p > .05$), indicating normality of distribution.

Table 2

Repeated-Measures ANCOVA for Suicidal Ideation and Spiritual Well-Being

Intervention	Outcome	Source	Sum of Squares	df	Mean Square	F	p	Eta Squared
Unified Transdiagnostic	Suicidal Ideation	Stages	153.06	1.29	118.65	47.19	< .001	0.604
		Stages × Group	72.46	1.29	56.17	22.34	< .001	0.419
		Error	100.55	39.99	2.51	—	—	—
	Spiritual Well-Being	Stages	2007.24	1.28	1570.34	185.19	< .001	0.787
		Stages × Group	1790.27	1.28	1400.60	165.17	< .001	0.772
		Error	336.01	39.63	8.48	—	—	—
Compassion-Based	Suicidal Ideation	Stages	128.21	1.36	94.60	38.73	< .001	0.548
		Stages × Group	54.68	1.36	40.34	16.52	< .001	0.340
		Error	105.93	43.37	2.44	—	—	—
	Spiritual Well-Being	Stages	609.44	1.61	379.23	102.55	< .001	0.762
		Stages × Group	489.44	1.61	304.56	82.36	< .001	0.720
		Error	190.17	51.43	3.70	—	—	—

Table 2 displays the repeated-measures ANCOVA results for suicidal ideation and spiritual well-being under the Unified Transdiagnostic Treatment and the Compassion-Based Approach. The within-subjects effects reveal that there was a statistically significant difference in both suicidal ideation and spiritual well-being across the pre-test, post-test, and follow-up stages ($p < .001$), as well as a significant interaction between time (stage) and group membership ($p < .001$). The partial eta-squared values show a substantial portion of the variance in each outcome explained by the interventions over time.

Table 3

Bonferroni Pairwise Comparisons Across Pre-Test, Post-Test, and Follow-Up

Intervention	Outcome	Stage 1	Stage 2	Mean Difference	Standard Error	p
Unified Transdiagnostic	Suicidal Ideation	Pre-test	Post-test	2.94*	0.34	< .001
		Pre-test	Follow-up	2.16*	0.39	< .001
		Post-test	Follow-up	−0.77*	0.17	< .001
	Spiritual Well-Being	Pre-test	Post-test	−10.43*	0.65	< .001
		Pre-test	Follow-up	−8.34*	0.69	< .001
		Post-test	Follow-up	2.10*	0.29	< .001
Compassion-Based	Suicidal Ideation	Pre-test	Post-test	2.69*	0.33	< .001
		Pre-test	Follow-up	1.84*	0.39	< .001
		Post-test	Follow-up	0.85*	0.19	< .001
	Spiritual Well-Being	Pre-test	Post-test	−5.81*	0.42	< .001
		Pre-test	Follow-up	−4.19*	0.50	< .001

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	Post-test	Follow-up	1.63*	0.31	< .001

Table 3 presents the Bonferroni-adjusted pairwise comparisons across the pre-test, post-test, and follow-up stages for each intervention separately. The results indicate that for both the Unified Transdiagnostic Treatment and the Compassion-Based Approach, suicidal ideation scores significantly decreased from pre-test to post-test and were maintained or further improved at follow-up ($p < .01$). Similarly, spiritual well-being scores significantly increased from pre-test to post-test and remained elevated at follow-up ($p < .01$), demonstrating the effectiveness of each intervention over time and the sustainability of their effects.

Table 4

Bonferroni Post Hoc Tests for Between-Group Comparisons

Outcome	Group 1	Group 2	Mean Difference	Standard Error	p
Suicidal Ideation	Control	Compassion-Based	1.90*	0.79	0.021
	Control	Unified Transdiagnostic	3.52*	0.81	< .001
	Compassion-Based	Unified Transdiagnostic	1.63*	0.78	0.043
Spiritual Well-Being	Control	Compassion-Based	−5.45*	2.65	0.045
	Control	Unified Transdiagnostic	−10.88*	2.69	< .001
	Compassion-Based	Unified Transdiagnostic	−5.43*	2.61	0.043

Table 4 shows the between-group comparisons (Control vs. Unified Transdiagnostic vs. Compassion-Based Approach) using the Bonferroni post hoc test at the post-test and follow-up stages. For suicidal ideation, both the Unified Transdiagnostic group and the Compassion-Based Approach group had significantly lower scores than the Control group ($p < .01$). Moreover, the Unified Transdiagnostic Treatment showed a stronger effect than the Compassion-Based Approach in reducing suicidal ideation ($p < .05$). For spiritual well-being, both interventions produced significantly higher scores than the Control ($p < .01$), and again the Unified Transdiagnostic Treatment outperformed the Compassion-Based Approach ($p < .05$).

4. Discussion and Conclusion

The present study aimed to compare the effectiveness of Unified Transdiagnostic Treatment and the Compassion-Based Approach on suicidal ideation and spiritual well-being among women victims of domestic violence. The findings indicated that Unified Transdiagnostic Treatment reduced suicidal ideation in these women. This result aligns with the prior studies (Liu et al., 2019; Norton & Paulus, 2016; Steele et al., 2018).

In explaining this finding, one may argue that Unified Transdiagnostic Treatment does not allow individuals to avoid harm; rather, it teaches them to face the intense emotions they experience in response to harmful conditions or trauma-related symptoms. Exposure to a distressing event can extend beyond focusing on a single event and contribute to the therapy's flexibility (Steele et al., 2018). The use of Unified Transdiagnostic Treatment enables individuals to focus more on the severe emotions they experience that interfere with their daily life. Therapists can address pervasive problems by working with past strong emotional experiences or those that appear during sessions. Rather than avoiding trauma-related content, this approach encourages individuals to face those emotions throughout treatment. Furthermore, the treatment process is based on each person's skills and can be flexibly adapted to their evolving needs. This approach leads to greater patient and therapist satisfaction, while also reducing symptoms and improving functioning in those exposed to trauma (Norton & Paulus, 2016).

The transdiagnostic approach focuses on maladaptive emotion regulation strategies and shared cognitive processes across mental disorders, making it effective for reducing emotional symptoms and improving quality of life. Unified Transdiagnostic Treatment relies on emotion regulation techniques that help individuals process and accept their negative emotions. This approach facilitates identifying and controlling thoughts influencing negative emotions and behaviors that generate negative emotions, and it provides adaptive coping strategies to manage thoughts, emotions, and behaviors. Such awareness may foster acceptance, constructive confrontation with problems, and greater resilience, thereby reducing suicidal thoughts (Steele et al., 2018). Additionally, the emotion regulation strategies inherent in Unified Transdiagnostic Treatment enable individuals to learn how to increase their tolerance of

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emotions and acquire new behavioral learning that can enhance their overall health. By encouraging individuals to reduce emotional behavior patterns and replace them with enjoyable activities, this approach alleviates depression and anxiety, improves functioning, enhances cognitive processing, and increases functional flexibility in women victims of domestic violence, which in turn reduces suicidal ideation.

The findings showed that Unified Transdiagnostic Treatment improved spiritual well-being among women victims of domestic violence. This result is consistent with the prior (Liu et al., 2019; Norton & Paulus, 2016; Steele et al., 2018). To explain this outcome, one might note that couples carry a multitude of memories, experiences, patterns, and lessons from childhood into the crucial stage of marriage, and these experiences inevitably challenge them. Therefore, one of the most vital changes that can be made in the lives of couples experiencing violence and marital infidelity is to enhance their spiritual well-being. Psychological interventions play a crucial role in managing and strengthening their psychological capacities. Unified Transdiagnostic Treatment emphasizes the functional and adaptive nature of emotions. It primarily seeks to correct maladaptive processes for regulating emotions, facilitating proper processing, and eliminating disproportionate responses to internal and external cues. It helps individuals learn to handle disruptive emotions and respond to them in more adaptive ways, aiming to reduce the intensity and frequency of detrimental emotional habits, as well as to improve functioning. In an integrative approach, thoughts, behaviors, and feelings dynamically interact, each playing a role in shaping emotional experiences (Liu et al., 2019; Norton & Paulus, 2016; Steele et al., 2018).

Therefore, the primary spiritual themes (positive mental states, self-awareness, God's healing power, spiritual support, and spiritual growth) and their subthemes (awareness of eternity, awareness of the spirit, freedom from fear, happiness regardless of circumstances, serving as an inspirational role model) can be strengthened with Unified Transdiagnostic Intervention techniques by enhancing psychological flexibility in the face of adverse events, regulating emotions through acceptance of unpleasant feelings, and substituting ineffective, avoidant behaviors with more adaptive ones (Steele et al., 2018). This, in turn, can improve one's relationship with oneself, God, and others and enhance the ability to manage life situations. Additionally, Unified Transdiagnostic Treatment includes strategies such as teaching emotional awareness, learning to observe emotional experiences, understanding maladaptive emotional avoidance, recognizing the negative impact of such avoidance, and identifying emotion-based behaviors to help individuals regulate their emotions. By emphasizing emotion regulation skills, this approach enables people to process especially negative emotions, thereby leading to greater acceptance of these emotions. Ultimately, this fosters increased spiritual well-being. Considering that living a quality, comfortable, and healthy life initially depends on accepting both negative and positive emotions and then balancing the reduction of negative emotions in a calm manner, Unified Transdiagnostic Treatment appears useful in improving spiritual well-being among women affected by marital violence.

The findings revealed that the Compassion-Based Approach reduced suicidal ideation among women victims of domestic violence. This result aligns with the prior studies (Ahmadi et al., 2019; Jabbari & Aghili, 2023). The role of the Compassion-Based Approach in reducing suicidal thoughts may be found within its educational content, positing that teaching self-compassion to individuals living with shame, self-harm, or self-injury is crucial for improving adaptive functioning. A fundamental characteristic of this approach is that when clients show empathy in their attention, thoughts, and behaviors, it diminishes their negative reactions to adverse circumstances (Gilbert, 2010). This approach recognizes that pain (physical or emotional) is part of the human experience and may give rise to self-injurious or suicidal thoughts, self-criticism, guilt, or shame. Consequently, through techniques such as self-regulation, mindfulness, and compassionate imagery, the approach attempts to modify or replace self-harm, suicidal behaviors, or self-criticism. It emphasizes that emotional imbalances lead to abnormal thoughts and behaviors, and implementing compassionate processes helps restore balance and strengthen normal functioning (Gilbert, 2014). Through receiving Compassion-Based Therapy, women victims of domestic violence become less critical of themselves and are better able to cope with challenging circumstances, thereby reducing tension, improving psychological well-being, and ultimately decreasing suicidal ideation.

The results also showed that the Compassion-Based Approach improved spiritual well-being in women victims of domestic violence, aligning with prior studies (Abdollahzadeh et al., 2020; Afshari, 2018; Ahmadi & Valizadeh, 2021; Alharbi et al., 2019; Birnie, 2010; Bodok-Mulderij et al., 2023). In explaining this finding, it can be noted that Compassion-Based Therapy may enhance

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interpersonal functioning and is linked to features such as empathy and altruism. Self-compassionate individuals are more likely to extend compassion to others—being kind to themselves allows them to exhibit kindness toward others who suffer. This highly positive psychological effect of the therapy fosters greater joy and higher levels of hope and gratitude. Because Compassion-Focused Therapy aims to gradually stimulate the emotion-focused system, strengthening mindfulness and acceptance skills, and because cognitive defusion from negative thoughts and emotions helps individuals to experience internal negative states in new ways, it reduces rumination on negative thoughts and self-judgment. Along with cognitive training, mindfulness-based programs, and relaxation, it promotes mental health (Ahmadi & Valizadeh, 2021). Improved mental health enables individuals to suffer less in confronting life's obstacles and find a sense of belonging to a higher power—believing in God—thus viewing life's difficulties from a more compassionate perspective, which can enhance spiritual well-being (Tamjidfar, 2022). Self-compassion serves as a safeguard against the negative consequences of shame, guilt, and self-blame. During the intervention, individuals consciously revisit life's hardships with compassion, achieving spiritual and physical tranquility through self-forgiveness, discovering true peace by drawing closer to God and accepting their destiny, and ultimately taking responsibility for their lives (Gilbert, 2009b). The acceptance and commitment gained from this intervention help participants manage and lessen psychological stress (Campbell, 2015). When individuals accept God's kindness toward themselves and creation, they view both positive and negative life events as part of divine will, and life's struggles lead them to constantly feel God's presence in their being, making them see life as valuable (Tamjidfar, 2022). Compassion is a notion close to the human disposition and fosters well-being and tranquility (Tamjidfar, 2022). Sometimes, individuals can harm themselves with negative thoughts, stress, and anxiety, and avoidance of self-harm or harm to others is a principal aspect of compassion. Hence, participants in Compassion-Based Therapy learn to avoid thoughts causing anxiety, thereby reducing anxiety and increasing their spiritual well-being.

The findings indicated that Unified Transdiagnostic Treatment had a greater effect on suicidal ideation than the Compassion-Based Approach. Based on previous research, no studies have compared the effectiveness of these two interventions on suicidal ideation. In explaining this result, one might note that Unified Transdiagnostic Treatment's three-component model of emotions helps individuals better understand the interplay of thoughts, feelings, and behaviors involved in emotional experiences. Participants learn to align their emotional experiences with this model, helping them gain awareness of triggers and behavioral consequences without getting entangled in emotional responses. This allows them to adopt emotional awareness with a more realistic perspective of the treatment plan. Moreover, this therapy involves confronting negative appraisals of internal and external threats (such as emotions and bodily feelings) and increasing cognitive flexibility. The cognitive interventions address two primary erroneous appraisals: an overestimation of risk (i.e., imagining a high likelihood of negative events) and catastrophizing (i.e., expecting extremely dire outcomes if negative events occur). Rather than eliminating or suppressing negative thoughts and appraisals or replacing them with adaptive, realistic ones, the Unified Transdiagnostic Treatment focuses on enhancing cognitive flexibility as an adaptive emotion regulation strategy. Patients are encouraged to apply cognitive reappraisal strategies not only before but also during and after emotional situations. Additionally, this therapy underscores the dynamic connection among behaviors, cognitions, and bodily sensations, crucial indicators in creating emotional experiences. This therapy thus helps identify thoughts influencing emotions and behaviors that generate negative emotions, which provides domestic violence victims with the necessary security to confront situations constructively and make essential life decisions. Consequently, this improves functional performance and psychological resilience, thereby reducing suicidal ideation. The combination of nonjudgmental, present-focused awareness during emotional experiences, heightened cognitive flexibility, and the use of cognitive reappraisal may have more lasting effects on suicidal ideation, thereby enhancing the efficacy of Unified Transdiagnostic Treatment. Consequently, it appears that, compared to the Compassion-Based Approach, Unified Transdiagnostic Treatment is more effective in reducing suicidal ideation among women victims of domestic violence.

The findings also showed that Unified Transdiagnostic Treatment had a more substantial impact on spiritual well-being than the Compassion-Based Approach. Based on prior research, no studies have compared the efficacy of these two interventions regarding spiritual well-being. A possible explanation is that one of the skills within Unified Transdiagnostic Treatment involves identifying and

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modifying maladaptive impulses or emotion-driven behaviors, a key component of exposure methods. One central function of exposure is likely to prevent emotion-related behavioral impulses and encourage alternative behaviors—an idea consistent with theories and evidence from the field of emotion, which hold that modifying such impulses is highly effective in emotional control. As Izard noted in 1971, "people learn to act differently and hence feel differently". Another skill in Unified Transdiagnostic Treatment is increasing awareness and tolerance of bodily sensations during interoceptive exposure. Regardless of diagnosis or specific disorder type, participants are asked to engage in exercises designed to elicit bodily sensations similar to normal anxiety and discomfort. However, under Unified Transdiagnostic Treatment, interoceptive exposure is also applied across different diagnoses to help participants become more aware of and tolerant toward bodily feelings, even if such sensations are not directly associated with their anxiety symptoms. During emotional exposure, patients learn the role of bodily sensations in emotional experiences and how behaviors and thoughts reciprocally intensify these sensations. Consequently, conscious exposure to destructive emotions and thoughts can more durably influence spiritual well-being, increasing the efficacy of Unified Transdiagnostic Treatment. Thus, it appears that, compared to the Compassion-Based Approach, Unified Transdiagnostic Treatment is more effective in enhancing spiritual well-being in women victims of domestic violence.

Overall, the study's findings indicate that both Unified Transdiagnostic Treatment and the Compassion-Based Approach can reduce suicidal ideation and improve spiritual well-being in women victims of domestic violence. Additionally, Unified Transdiagnostic Treatment had a more significant role than the Compassion-Based Approach in reducing suicidal ideation and enhancing spiritual well-being. Therefore, Unified Transdiagnostic Treatment can be utilized alongside pharmacological and medical treatments as a viable approach to assist women victims of domestic violence.

5. Suggestions and Limitations

This research also encountered certain limitations. Only self-report questionnaires were used to measure the study variables, which may have been influenced by social desirability bias. The statistical population was limited to women victims of domestic violence visiting social emergency centers and family counseling clinics in Tehran. Cultural variations across different cities suggest caution when generalizing the findings. Moreover, the cross-sectional nature of the study might not fully capture the efficacy of Unified Transdiagnostic Treatment and the Compassion-Based Approach. Another limitation involves not controlling for factors such as the duration of exposure to domestic violence, its severity, and physiological and biological indicators related to emotional factors. Future studies should include additional measures (e.g., interviews or performance-based instruments) to increase measurement precision and reassure participants about confidentiality. To enhance generalizability, future research should consider other traumas, include men who are victims of domestic violence, and involve different cities to enable broader comparisons. Longitudinal studies with extended follow-up intervals are recommended to assess the durability of intervention effects. Researchers should also control for intervening variables such as the duration and severity of domestic violence and other cognitive and emotional factors. In family education programs, issues related to domestic violence—such as improving spiritual well-being and reducing suicidal ideation—could be incorporated. Psychologists and family counselors should identify women victims of domestic violence, raise their awareness, and refer them to treatment centers, thereby preventing unhealthy marital relationships and new victims of domestic violence. A systematic program for families prior to marriage and for married couples could be established to teach Unified Transdiagnostic Treatment, enabling individuals to recognize and effectively manage their emotions, thus functioning more successfully in the marital context. Addressing specific stressors associated with domestic violence and highlighting their interrelationships can increase the effectiveness of both Unified Transdiagnostic Treatment and the Compassion-Based Approach. Clinicians and professionals should allow sufficient time for change in domestic violence during the planning of these interventions, given that improvements in this domain can significantly predict better mental health outcomes.

Authors' Contributions

All authors have contributed significantly to the research process and the development of the manuscript.

Declaration

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

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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