

Comparison of the Effectiveness of Compassion-Focused Therapy and Domestic Violence-Focused Couple Therapy on Marital Burnout and Emotion Regulation in Women Affected by Domestic Violence in Dezful

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ABSTRACT

The present study aimed to compare the effectiveness of compassion-focused therapy and domestic violence-focused couple therapy on marital burnout and emotion regulation among women affected by domestic violence in Dezful. This study employed a quasi-experimental design with a pretest-posttest control group. The statistical population consisted of all women who had experienced domestic violence and attended psychological centers in Dezful in 2026. A total of 45 participants were selected through convenience sampling and subsequently assigned, using simple randomization, to two experimental groups and one control group. The first experimental group (n = 15) received compassion-focused therapy, the second experimental group (n = 15) received domestic violence-focused couple therapy, and the control group (n = 15) received no intervention. The research instruments were the Marital Burnout Measure (Pines, 1996) and the Emotion Regulation Questionnaire (Gross & John, 2003). Data were analyzed using univariate and multivariate analyses of covariance (ANCOVA and MANCOVA) and the Bonferroni post hoc test. The findings indicated that both therapeutic interventions had significant effects on marital burnout and emotion regulation ($p < .001$). The results of the Bonferroni test showed that domestic violence-focused couple therapy produced a greater effect on marital burnout (12.12) than compassion-focused therapy. Likewise, the Bonferroni test indicated that domestic violence-focused couple therapy was more effective than compassion-focused therapy in improving emotion regulation (2.92). The findings underscore the importance of implementing both therapeutic approaches to reduce marital burnout and improve emotion regulation among women affected by domestic violence.

Keywords: emotion regulation, domestic violence, marital burnout, couple therapy, self-compassion

1. Introduction

Domestic violence is a major psychological, relational, and public health concern that can profoundly affect women's emotional well-being, interpersonal functioning, and long-term adjustment. It encompasses a range of physically, psychologically, emotionally, sexually, and economically coercive behaviors occurring within intimate or family relationships and may produce consequences that persist long after an acute violent episode has ended. Women exposed to domestic violence commonly experience fear, emotional insecurity, shame, social withdrawal, hopelessness, and disruptions in their capacity to establish a stable sense of safety within intimate relationships. The burden of domestic violence is not restricted to physical injury; rather, repeated exposure to threatening, humiliating, or coercive interpersonal experiences can alter how women perceive themselves, their partners, and the marital relationship as a whole. Research has shown that domestic violence is associated with a variety of psychological vulnerabilities, including hopelessness and difficulties in emotional expression, suggesting that the emotional consequences of violence may become embedded in victims' everyday psychological functioning (Hervika et al., 2021). Domestic violence is also related to broader relational and contextual factors, and emotional schemas as well as personality-related characteristics have been shown to contribute to patterns of violence in intimate relationships (Masoudzadeh et al., 2021). Moreover, domestic violence may interact with women's reproductive, familial, and social circumstances, further demonstrating that violence against women is a multidimensional phenomenon rather than an isolated interpersonal event (Raifman et al., 2021). The increased attention given to domestic violence during major social crises, such as the COVID-19 pandemic, has further emphasized the vulnerability of women living in unsafe family environments and the need for psychological services that address both immediate and enduring emotional consequences of violence (Gulati & Kelly, 2020).

Exposure to domestic violence can progressively undermine the quality of intimate relationships and may contribute to the development of marital burnout. Marital burnout refers to a state of emotional, psychological, and physical exhaustion arising when persistent relational stress, unmet expectations, repeated conflict, and a sense of helplessness gradually erode the positive emotional resources of the relationship. Unlike temporary marital dissatisfaction, burnout reflects a more pervasive process in

which individuals may become emotionally depleted, detached, discouraged, and increasingly unable to perceive the relationship as a source of support or intimacy. In women exposed to domestic violence, this process may be particularly severe because relational stress occurs in an interpersonal context characterized by fear, coercion, recurrent emotional injury, and compromised trust. Research indicates that marital burnout is associated with several psychological and interpersonal variables. For example, marital burnout has been linked to poorer mental health and emotional difficulties among women affected by relational betrayal, indicating that emotional depletion within marriage may coexist with substantial psychological distress (Ghasemi et al., 2023). Attitudes toward infidelity and marital maladjustment have also been associated with marital burnout, highlighting the importance of relational beliefs, expectations, and perceived violations of trust in the development of burnout (Nikmanesh & Amiri Moghadam, 2020). Furthermore, predictive models have suggested that differentiation of self, emotional intelligence, mental health, and resilience are relevant factors in explaining individual differences in marital burnout (Mahdigholi et al., 2022).

The development of marital burnout is therefore likely to involve complex interactions between emotional vulnerabilities, cognitive interpretations, communication processes, and relational experiences. Executive functions and social-cognitive capacities may also play a role in the formation and persistence of marital burnout. Babaei et al. demonstrated that theory of mind can mediate the association between executive functioning and marital burnout, suggesting that the capacity to understand one's own and a partner's mental states may influence how individuals process conflict and emotional strain within marriage (Babaei et al., 2024). When a relationship is marked by domestic violence, however, the erosion of trust and psychological safety may make constructive interpretation of the partner's intentions considerably more difficult. Persistent threat may shift attention away from mutuality and intimacy toward vigilance and self-protection, thereby intensifying emotional exhaustion. Consequently, therapeutic approaches designed to reduce marital burnout in women affected by domestic violence should not focus exclusively on communication or relationship satisfaction but should also consider trauma-related emotional responses, shame, self-criticism, disrupted trust, and patterns of emotional avoidance.

One of the central psychological processes that may be disrupted by domestic violence is emotion regulation.

Emotion regulation refers to the processes through which individuals monitor, evaluate, and modify their emotional reactions in accordance with personal goals and situational demands. Effective emotion regulation enables individuals to experience difficult emotions without becoming overwhelmed by them and to use adaptive cognitive and behavioral strategies when responding to interpersonal stress. In contrast, emotion dysregulation may involve excessive suppression, emotional avoidance, impulsive reactions, rumination, difficulty identifying or tolerating emotions, and ineffective attempts to reduce distress. Women who have experienced domestic violence may face repeated high-intensity emotional states, including fear, anger, shame, guilt, sadness, helplessness, and resentment. Under conditions of chronic threat, these emotional responses may become difficult to regulate because they are continuously reactivated by relational cues and memories of harmful experiences. Homayouni et al. showed that positive mindfulness can reduce internalized shame, experiential avoidance, and emotion dysregulation among women exposed to violence, supporting the view that interventions targeting internal emotional processes can be beneficial for this population (Homayouni et al., 2022). Similarly, emotion-focused therapy has been found to improve rejection-related experiences, marital adjustment, and emotion regulation in women affected by domestic violence (Moeini et al., 2022). Emotion-focused intervention has also demonstrated beneficial effects on assertiveness and anger rumination among women who have experienced domestic violence, indicating that therapeutic work with emotions may help reduce maladaptive cognitive-emotional cycles following victimization (Leshani, 2023).

Emotion regulation is closely linked to how individuals process trauma, self-evaluate, and respond to relational threat. Traumatic interpersonal experiences can generate persistent negative appraisals concerning personal worth, safety, responsibility, and trust. These appraisals may reinforce self-blame and shame and, in turn, intensify emotional dysregulation. Research on trauma has demonstrated that trauma-related appraisals, emotion regulation difficulties, and low self-compassion are associated with greater posttraumatic stress symptoms following childhood abuse, indicating that the capacity to relate to oneself compassionately may act as an important protective mechanism when individuals are confronted with trauma-related distress (Barlow et al., 2017). The psychological effects of domestic violence may be maintained not only by memories of violence itself but also

by internalized criticism, shame, and beliefs of personal inadequacy. In this context, interventions that reduce hostile self-evaluation and strengthen emotional tolerance may be especially relevant.

Compassion-focused therapy is one therapeutic approach that directly targets shame, self-criticism, emotional threat, and difficulties in self-soothing. Compassion-focused therapy seeks to strengthen individuals' capacity to respond to suffering with warmth, understanding, courage, and supportive motivation rather than with self-attack, avoidance, or punitive self-judgment. The approach is particularly relevant for individuals whose psychological distress is associated with intense shame or self-criticism. Irons and Lad emphasized the applicability of compassion-focused therapy for complex trauma, particularly when shame and harsh self-criticism are prominent therapeutic concerns (Irons & Lad, 2017). Compassion-based therapeutic methods can help clients distinguish between trauma-related self-blame and realistic responsibility, cultivate an internal sense of safety, and learn to approach painful emotional experiences without excessive avoidance. In women exposed to domestic violence, these capacities may be especially important because prolonged interpersonal victimization may produce internalized beliefs that one is weak, defective, responsible for abuse, or unworthy of care.

Evidence supporting compassion-focused interventions has accumulated across several clinical and nonclinical populations. A randomized controlled trial of an internet-based compassion-focused intervention for highly self-critical individuals demonstrated that compassion-oriented training can reduce maladaptive self-evaluation and improve psychological outcomes (Krieger et al., 2019). Compassion-focused group treatment has also shown promise in addressing anger among veterans with posttraumatic stress disorder, suggesting that compassion can be used not only to reduce self-criticism but also to improve the regulation of intense affective states such as anger (Grodin et al., 2020). Self-compassion has additionally been associated with depression, anxiety, and resilience in adults experiencing chronic medical conditions, reinforcing its potential role as a psychological resource in the presence of significant stress (Baker et al., 2020). Experimental evidence also indicates that brief self-compassion interventions may improve body-related psychological outcomes in sexual minority men, demonstrating that self-compassion processes can be therapeutically relevant across diverse forms of distress and stigma-related vulnerability (Grey et al., 2022). Collectively,

these findings suggest that compassion-based approaches may influence emotional well-being through mechanisms including reduced self-criticism, increased emotional tolerance, and improved resilience.

The relevance of self-compassion may be particularly pronounced among survivors of domestic violence. Allen et al. reported beneficial emotional and cognitive outcomes associated with shelter stay and self-compassion support groups among domestic violence survivors, underscoring the potential value of self-compassion-oriented interventions in this population (Allen et al., 2021). Compassion-focused therapy may help women affected by violence reinterpret trauma-related shame, reduce self-blame, and create a more supportive internal response to distress. Furthermore, compassion training may contribute to improved interpersonal functioning. Research among couples has indicated that compassion-focused therapy can enhance marital intimacy and emotion regulation, suggesting that cultivating compassion may influence not only intrapersonal processes but also relational interactions (Shojaei Vazhnany et al., 2020). Because marital burnout involves emotional exhaustion and loss of positive relational engagement, an intervention that strengthens self-compassion and emotional regulation may help women reduce the internal psychological burden associated with repeated relational distress. However, compassion-focused therapy primarily targets internal emotional and self-relational processes and may not directly modify dysfunctional couple interaction patterns to the same extent as structured couple-based interventions.

Couple therapy represents another important therapeutic framework for addressing relationship difficulties, although its application in the context of domestic violence requires careful assessment of safety, the nature of violence, coercion, and the responsibility of the perpetrating partner. Couple-based interventions are not appropriate for all forms or severities of intimate partner violence, particularly where coercive control, severe fear, or ongoing high-risk violence compromises safe conjoint participation. Nevertheless, research has indicated that carefully selected couples experiencing situational couple violence may benefit from structured interventions specifically adapted to address violence and relational patterns. Stith et al. described international adaptation of a treatment program for situational couple violence, highlighting the importance of culturally sensitive and safety-informed couple interventions that simultaneously address violent behavior and relational functioning (Stith et al., 2019). Keilholtz and Spencer

similarly emphasized that assessment of intimate partner violence should precede couple treatment and that treatment modality must be selected according to the type, severity, and context of violence (Keilholtz & Spencer, 2022). These considerations are essential because conjoint treatment must never imply shared responsibility for abuse or compromise the safety of the affected partner.

Domestic violence-focused couple therapy may offer therapeutic advantages when violence occurs within a pattern that can be safely addressed through conjoint work. Such interventions can target escalation cycles, poor conflict management, hostile communication, emotion dysregulation, avoidance, and recurring interpersonal triggers while simultaneously emphasizing accountability and safety. Emotionally focused couple therapy has been adapted to violent couple patterns with an emphasis on de-escalating interactions and interrupting cycles that maintain relational aggression (Slootmaeckers & Migerode, 2020). Cognitive-behavioral conjoint approaches have also been applied in complex relational situations involving trauma histories and domestic violence, illustrating how structured couple work can integrate trauma-related symptoms with interpersonal functioning (Fedynich et al., 2021). More broadly, couple interventions that target communication and emotional expression have demonstrated favorable outcomes. Narrative therapy has been shown to improve communication skills, emotional expression, and empathy among couples preparing for marriage, indicating the value of addressing interpersonal meaning-making and communication processes in relational interventions (Boostani-Kashani et al., 2021). Likewise, mindfulness- and imagery-based couple interventions have been associated with improvements in intimacy and commitment in couples facing psychological and relational challenges (Beheshtinejad et al., 2022).

Interventions that strengthen adaptive couple functioning may therefore influence both marital burnout and emotion regulation by changing the interpersonal environment in which emotions are elicited and maintained. Encouragement-based couple therapy has been found to improve psychological flexibility, cognitive emotion regulation, and communication patterns among couples, supporting the proposition that changes in couple interactions can facilitate broader emotional adaptation (Homayooni et al., 2023). Similarly, interventions focusing on marital relational processes have demonstrated effectiveness in reducing marital burnout in women who have experienced serious relationship disruptions. For

example, both the Walsh and Olson approaches have been reported to improve communication patterns and marital burnout among women affected by marital infidelity (Aghabozorgi et al., 2019). Such findings indicate that interventions directed at relationship processes can potentially reduce emotional exhaustion by improving communication, restructuring maladaptive patterns, and increasing the sense that conflict can be managed more constructively.

At the same time, women affected by domestic violence may require interventions that are responsive to both intrapersonal trauma and interpersonal dysfunction. Treatment focused exclusively on the couple may fail to adequately address self-criticism, internalized shame, or trauma-related emotional distress, whereas an exclusively individual compassion-based approach may not directly alter dyadic patterns such as hostile communication, escalation, withdrawal, or unmet relational needs. This distinction creates a clinically important question regarding the comparative effectiveness of these therapeutic approaches. Compassion-focused therapy may be especially effective in reducing shame, emotional distress, and self-directed hostility, whereas domestic violence-focused couple therapy may have a more direct impact on patterns of interaction, conflict management, and marital burnout through work with relational dynamics. Contemporary findings concerning acceptance-based treatment further support the usefulness of interventions that reduce experiential avoidance and increase adaptive psychological engagement among women affected by domestic violence; acceptance and commitment therapy, for example, has been used to address alexithymia and personal values in women victims of domestic violence (Taghipour, 2026). This growing body of evidence suggests that psychological treatment for women exposed to domestic violence should address emotional awareness, regulation, self-related processing, and relational functioning simultaneously or through appropriately integrated modalities.

Other therapeutic studies with domestic violence survivors also reinforce the importance of tailoring intervention to the distinctive emotional needs of this population. Art psychotherapy has shown beneficial effects on depression, anxiety, and hopelessness in female survivors of domestic violence with posttraumatic stress disorder, suggesting that emotionally expressive interventions can facilitate psychological recovery when verbal processing alone may be insufficient (Özkafacı & Eren, 2020). In parallel, research showing associations between emotional

intelligence, emotional expressiveness, and hopelessness in women experiencing domestic violence indicates that the ability to identify and express affective states is closely connected with psychological adjustment (Hervika et al., 2021). These findings are consistent with the broader view that interventions for domestic violence survivors must enhance the ability to process intense emotions rather than merely suppress them. Improved emotional processing may also reduce the accumulation of frustration, resentment, and helplessness that contributes to marital burnout.

The present investigation is especially important because marital burnout and emotion regulation represent interconnected yet distinguishable treatment targets. Marital burnout reflects cumulative deterioration in the emotional and relational experience of marriage, whereas emotion regulation represents a broader psychological capacity that shapes how individuals respond to distress across contexts. Domestic violence can negatively influence both outcomes simultaneously. Women who repeatedly experience threatening or invalidating interactions may become emotionally exhausted while also relying on maladaptive strategies such as suppression, rumination, avoidance, or reactive anger. Interventions that improve emotion regulation may consequently reduce the intensity of relational distress, while interventions that restructure relational patterns may decrease the frequency of emotional triggers that produce dysregulation. Theoretical and empirical findings therefore support evaluating these outcomes together rather than independently.

Despite the growing evidence for compassion-focused interventions, emotion-focused treatments, and couple-based approaches, direct comparisons between compassion-focused therapy and domestic violence-focused couple therapy in women affected by domestic violence remain limited. Existing studies have often examined one therapeutic modality, one psychological outcome, or populations experiencing marital difficulties without specifically focusing on women exposed to domestic violence. In addition, compassion-based research has frequently emphasized self-criticism, trauma, resilience, anger, or emotional symptoms, whereas domestic violence-focused couple interventions have concentrated more heavily on conflict patterns, safety, and relational restructuring. Comparing the two approaches may therefore clarify whether an intrapersonal compassion-oriented intervention and an interpersonal couple-based intervention differ in their effects on marital burnout and emotion regulation. Such evidence can contribute to more precise

therapeutic decision-making and may help clinicians select interventions according to the dominant psychological and relational needs of women affected by domestic violence.

Accordingly, the aim of the present study was to compare the effectiveness of compassion-focused therapy and domestic violence-focused couple therapy on marital burnout and emotion regulation among women affected by domestic violence in Dezful.

2. Methods and Materials

2.1. Study Design and Participants

The present study employed a quasi-experimental pretest–posttest design with two intervention groups and one control group. The statistical population consisted of all women affected by domestic violence who had attended two psychological counseling centers in Dezful, Iran, during 2026. From this population, 45 eligible women were recruited through convenience sampling and subsequently assigned by simple random allocation to three groups: a compassion-focused therapy group ($n = 15$), a domestic violence-focused couple therapy group ($n = 15$), and a control group ($n = 15$). The inclusion criteria were having experienced domestic violence within the previous six months or more recently; not participating in any concurrent psychological, psychoeducational, or therapeutic training program during the intervention period; receiving complete information regarding the nature of the intervention, including its individual and group-related aspects, session duration, and therapeutic objectives; providing written informed consent to participate in the study; obtaining a score above the predefined cutoff of 60 on the Marital Burnout Measure; and obtaining a score below the cutoff of 35 on the Emotion Regulation Questionnaire. The exclusion criteria included withdrawal of consent or unwillingness to continue participation at any stage of the study and absence from more than two intervention sessions. Ethical principles were observed throughout the research process. These included respect for participants' autonomy and right to withdraw from the study, attention to their psychological well-being, avoidance of unnecessary distress or scientific deception, acquisition of written informed consent, adherence to the principle of nonmaleficence, protection of participants' identities and personal information, and maintenance of confidentiality. The researchers also attempted to minimize researcher bias and ensure that data collection, intervention delivery, and interpretation of the findings were not influenced by personal assumptions or

unjustified preconceptions. After completion of the pretest assessments, the two experimental groups received their respective interventions, whereas participants in the control group received no intervention during the study period and were placed on a waiting list. To address ethical considerations associated with withholding treatment, members of the control group were offered the opportunity to participate in therapeutic sessions after completion of the study.

2.2. Instruments

Marital Burnout Measure. The Marital Burnout Measure was originally developed by Pines (1996) as a 20-item instrument designed to assess the degree of emotional and psychological exhaustion, discouragement, and loss of positive affect toward one's spouse and marital relationship. The instrument assesses three major dimensions of marital burnout: physical exhaustion, characterized by fatigue, weakness, and sleep disturbances; emotional exhaustion, reflected in feelings such as depression, hopelessness, and being trapped; and psychological exhaustion, including feelings of worthlessness, frustration, disappointment, and anger toward one's spouse. Sixteen items are negatively worded and address experiences such as fatigue, distress, and worthlessness, whereas four items are positively worded and refer to experiences such as happiness and feeling energetic. Items are rated on a 7-point Likert-type scale ranging from 1 (never) to 7 (always), indicating the frequency with which respondents experience each condition in their marital relationship. The four positively worded items are reverse-scored. Total scores range from 20 to 140, with higher scores representing greater marital burnout; a score above 60 was considered indicative of a relatively high level of marital burnout in the present study. Previous psychometric evaluations have demonstrated satisfactory reliability for the measure. Pines (1998) reported a one-month test–retest reliability coefficient of .76 and Cronbach's alpha coefficients ranging from .91 to .93. In an Iranian sample, Sadati et al. (2014) reported a Cronbach's alpha coefficient of .79 and provided evidence of convergent validity, with a correlation coefficient of .54 with a related measure of marital burnout. Naim (2008) also reported satisfactory reliability coefficients of .85 and .82 using Cronbach's alpha and split-half methods, respectively. In the present study, the internal consistency of the instrument was satisfactory, with a Cronbach's alpha coefficient of .82.

Emotion Regulation Questionnaire. Emotion regulation was assessed using the Emotion Regulation Questionnaire developed by Gross and John (2003). This 10-item self-report instrument was designed to evaluate individual differences in the habitual use of two major emotion-regulation strategies: cognitive reappraisal and expressive suppression. Cognitive reappraisal refers to modifying the interpretation or appraisal of an emotion-eliciting situation in order to alter its emotional impact, whereas expressive suppression refers to inhibiting the behavioral expression of an emotional response after the emotion has already been generated. Participants respond to items on a 7-point Likert-type scale, with items assessing how individuals typically manage and modify their emotional experiences. An example of the type of content assessed by the questionnaire concerns changing one's thoughts about a situation in order to alter the intensity of an emotional experience. Scores for each subscale are calculated by summing the scores of the items corresponding to that dimension, and an overall score can also be obtained by summing the responses across all items. In the present study, total scores ranged from 10 to 70, with higher scores interpreted as reflecting a higher overall level of emotion regulation; a score of 35 was considered the reference cutoff point. The psychometric properties of the Persian version have previously been reported as acceptable. Farajpour Niri (2018) reported satisfactory content, face, and criterion-related validity and found Cronbach's alpha coefficients greater than .77. In the current study, the overall internal consistency coefficient of the questionnaire, assessed using Cronbach's alpha, was .82.

2.3. Interventions

Compassion-Focused Therapy. Participants assigned to the first experimental group received an eight-session compassion-focused therapy intervention based on the model proposed by Gilbert (2010). Each session lasted approximately 90 minutes and was conducted once per week. The intervention was adapted to address the emotional, cognitive, and relational consequences commonly experienced by women exposed to domestic violence, particularly shame, self-criticism, emotional dysregulation, guilt, and marital burnout. The first session focused on establishing a therapeutic alliance, normalizing trauma-related responses, introducing the three-system model of emotional regulation involving threat, drive, and soothing systems, and explaining the threat-safety cycle; participants were assigned soothing-rhythm breathing as

home practice. The second session addressed shame and self-criticism through identification of the "critical self," differentiation of personal identity from traumatic experiences, and daily monitoring of episodes of internal self-attack. The third session focused on cultivating self-compassion by developing a compassionate-self identity and supportive internal stance; compassionate imagery exercises, including visualization of a safe place and a compassionate figure, were introduced. The fourth session concentrated on guilt and responsibility by differentiating adaptive guilt, which can facilitate responsibility-taking, from toxic shame and global self-condemnation; participants were asked to write a compassionate letter to wounded or traumatized aspects of themselves. The fifth session emphasized emotion regulation and anger management through the use of compassionate capacities to tolerate difficult emotions, and participants practiced a mindful pause during periods of heightened emotional arousal. The sixth session focused specifically on the marital relationship and marital burnout by examining relationship expectations, identifying patterns of emotional depletion, and encouraging self-compassion during difficult marital interactions; compassionate boundary-setting was practiced as a homework assignment. The seventh session addressed compassion toward others while carefully distinguishing compassion from tolerating abuse or excusing violent behavior. The therapeutic emphasis was on reducing persistent resentment and anger when this served the participant's own psychological recovery, and self-forgiveness rather than obligatory forgiveness of the perpetrator was emphasized as a means of reducing shame. The eighth and final session focused on consolidation of acquired skills, relapse prevention, review of therapeutic progress, and development of an individualized compassion-based daily self-care plan. Throughout the intervention, participants were encouraged to practice the acquired techniques between sessions and to apply self-compassion without compromising personal safety or appropriate interpersonal boundaries.

Domestic Violence-Focused Couple Therapy. The second experimental group received domestic violence-focused couple therapy based on the protocol described by Stith et al. (2007). The program consisted of 12 weekly 90-minute sessions, with therapeutic content organized around safety, responsibility for violent behavior, emotion regulation, constructive communication, relational repair, and prevention of recurrence. Because the intervention addressed domestic violence, safety assessment and risk

management were treated as central components throughout treatment. During Sessions 1 and 2, the therapist conducted a detailed safety and risk assessment, established the therapeutic alliance, clarified treatment expectations, and developed an explicit safety agreement. Participants also completed assessments related to conflict-resolution styles and reviewed the safety agreement as part of their between-session work. Sessions 3 and 4 focused on responsibility-taking and recognition of patterns associated with violence. Particular emphasis was placed on identifying violent or coercive behavioral patterns and ensuring that responsibility for perpetrating violence was not transferred to the victim. Participants identified triggers associated with escalation and developed an individualized “anger road map” to recognize the sequence of cognitive, emotional, physiological, and interpersonal events preceding aggressive behavior. Sessions 5 and 6 concentrated on emotion regulation and impulse control. Relaxation strategies were taught, the cycle of violence was examined, and participants learned to identify escalating emotional arousal before conflict reached a dangerous level. The structured time-out technique was introduced and practiced as a strategy for interrupting escalating conflicts while preserving safety. Sessions 7 and 8 addressed communication reconstruction and the reduction of maladaptive shame. The therapeutic setting was used to facilitate appropriate expression of guilt, shame, hurt, and vulnerability without blame, intimidation, or coercion. Reflective listening exercises were introduced to enhance accurate understanding and nonjudgmental communication between partners. Sessions 9 and 10 focused more directly on marital burnout and relational disengagement by identifying unmet emotional and relational needs, examining avoidance and withdrawal patterns, and replacing hostile or defensive exchanges with nonhostile discussion of emotional needs. Participants practiced structured conversations designed to express needs without criticism, threat, or escalation. Sessions 11 and 12 were devoted to consolidation of therapeutic gains and prevention of recurrence. Progress across treatment was reviewed, potential high-risk situations and early warning signs of relapse were anticipated, and previously learned safety, emotion-regulation, communication, and conflict-management skills were integrated into an individualized relapse-prevention and relationship-rebuilding plan. Across all sessions, the continuation of conjoint therapeutic work was contingent on adequate attention to safety, and the intervention did not frame the victim as responsible for the partner’s violent behavior.

2.4. Data analysis

Data were analyzed at both descriptive and inferential levels using IBM SPSS Statistics version 26. Descriptive statistics, including the mean and standard deviation, were calculated to summarize participants’ scores on marital burnout and emotion regulation at the pretest and posttest stages. At the inferential level, multivariate analysis of covariance (MANCOVA) was used to examine the overall effects of the interventions on the dependent variables while statistically controlling for baseline pretest scores. Where appropriate, separate univariate analyses of covariance (ANCOVAs) were subsequently conducted for marital burnout and emotion regulation to determine the effect of group membership on each outcome after adjustment for corresponding pretest scores. Before performing the covariance analyses, the relevant statistical assumptions, including normality of the distributions, homogeneity of variances, homogeneity of covariance matrices, linear relationships between covariates and dependent variables, and homogeneity of regression slopes, were examined. Following significant omnibus effects, Bonferroni-adjusted pairwise comparisons were used to determine the pattern of differences among the compassion-focused therapy, domestic violence-focused couple therapy, and control groups while controlling for inflation of the Type I error rate due to multiple comparisons. All statistical tests were conducted using a two-tailed significance level of $p < .05$.

3. Findings and Results

The demographic findings of the present study showed that the mean age and standard deviation of participants in the compassion-focused therapy group were 32.53 and 2.38 years, respectively. Regarding educational level, 33.3% had completed middle school, 53.3% had a high school diploma, and 13.3% held a bachelor’s degree. In the domestic violence-focused couple therapy group, the mean age and standard deviation of participants were 34.00 and 1.36 years, respectively; 33.3% had completed middle school, 40.0% had a high school diploma, and 26.7% held a bachelor’s degree. In the control group, the mean age and standard deviation were 33.53 and 2.56 years, respectively; 20.0% had completed middle school, 46.7% had a high school diploma, and 33.3% held a bachelor’s degree. The descriptive and inferential findings of the study are presented below. Table 1 presents the means and standard deviations of marital burnout and emotion regulation scores for the two experimental groups, namely compassion-focused therapy

and domestic violence-focused couple therapy, and the control group at the pretest and posttest stages.

Table 1

Descriptive Statistics for Marital Burnout and Emotion Regulation in the Experimental and Control Groups (n = 15 per group)

Variable	Group	Stage	Mean	SD
Marital burnout	Compassion-focused therapy	Pretest	68.34	1.20
		Posttest	58.23	0.876
	Domestic violence-focused couple therapy	Pretest	69.37	1.34
		Posttest	57.31	0.768
	Control	Pretest	69.36	1.34
		Posttest	69.43	1.45
Emotion regulation	Compassion-focused therapy	Pretest	33.45	1.43
		Posttest	36.52	1.52
	Domestic violence-focused couple therapy	Pretest	32.52	1.38
		Posttest	37.60	1.56
	Control	Pretest	33.42	1.40
		Posttest	34.68	0.569

As shown in Table 1, differences were observed between the pretest and posttest scores of the dependent variables. Before conducting the main analyses, the assumptions underlying multivariate analysis of covariance were examined. The results of the Kolmogorov–Smirnov test confirmed the normality of the data distributions for all variables ($p > .05$). Levene’s test was also used to examine the homogeneity of error variances across the groups, and the results indicated that this assumption was satisfied for marital burnout ($p = .259$) and emotion regulation ($p = .541$), as both values exceeded .05. In addition, Box’s M test for assessing the homogeneity of variance–covariance matrices was nonsignificant, Box’s $M = 10.90$, $F = 0.883$, $p = .543$, indicating that this assumption was also met. The assumption of homogeneity of regression slopes was examined by evaluating the interaction between group membership and pretest scores and was likewise confirmed. Therefore, the use of multivariate analysis of covariance to test the study hypotheses was considered appropriate.

To control for the effects of pretest scores on posttest outcomes across the experimental and control groups,

multivariate analysis of covariance (MANCOVA) was conducted. The significance levels associated with Pillai’s trace, Wilks’ lambda, Hotelling’s trace, and Roy’s largest root were all below .05 for the multivariate comparison of posttest marital burnout and emotion regulation scores across the experimental and control groups while controlling for pretest scores. Moreover, the F statistics and significance levels of the multivariate indices indicated that the linear combination of the dependent variables differed significantly according to group membership. Wilks’ lambda was .020, with $F = 114.892$, $p < .001$, indicating that the overall multivariate analysis of covariance was statistically significant. Thus, the effects of compassion-focused therapy and domestic violence-focused couple therapy on marital burnout and emotion regulation among women affected by domestic violence in Dezful differed significantly across the study groups. The univariate analyses of covariance for the dependent variables are presented in Table 2.

Table 2

Summary of Analysis of Covariance Results for Marital Burnout and Emotion Regulation

Variable	Source	Sum of Squares	df	Mean Square	F	p	Effect Size
Marital burnout	Pretest	0.612	1	0.612	0.492	.487	.012
	Group	331.774	2	165.887	133.39	< .001	.86
	Error	50.988	41	1.244	—	—	—
Emotion regulation	Pretest	0.213	1	0.213	0.165	.675	.004
	Group	907.40	2	453.70	444.82	< .001	.95
	Error	41.82	41	1.03	—	—	—

The results presented in Table 2 indicate that, after controlling for the effects of pretest scores, the differences among the study groups in posttest marital burnout, $F = 133.39$, $p < .001$, and emotion regulation, $F = 444.82$, $p < .001$, were statistically significant. The effect-size values indicated that 86% of the variance in posttest marital burnout and 95% of the variance in posttest emotion regulation were attributable to group membership and, consequently, to the

therapeutic interventions, namely compassion-focused therapy and domestic violence-focused couple therapy. These findings demonstrate substantial intervention effects. To examine pairwise differences among the experimental and control groups and to compare the relative effects of the two interventions on the outcome variables, Bonferroni-adjusted post hoc comparisons were performed. The results are presented in Table 3.

Table 3

Bonferroni Post Hoc Comparisons of Group Differences in Marital Burnout and Emotion Regulation

Variable	Group 1	Group 2	Mean Difference	p
Marital burnout	Compassion-focused therapy	Domestic violence-focused couple therapy	0.92	< .001
	Compassion-focused therapy	Control	11.20	< .001
	Domestic violence-focused couple therapy	Control	12.12	< .001
Emotion regulation	Compassion-focused therapy	Domestic violence-focused couple therapy	1.80	< .001
	Compassion-focused therapy	Control	1.84	< .001
	Domestic violence-focused couple therapy	Control	2.92	< .001

The results of the Bonferroni post hoc test presented in Table 3 showed that both compassion-focused therapy and domestic violence-focused couple therapy differed significantly from the control condition in terms of marital burnout. The mean difference between the control group and the compassion-focused therapy group was 11.20, whereas the mean difference between the control group and the domestic violence-focused couple therapy group was 12.12. Overall, based on the magnitude of the mean differences, domestic violence-focused couple therapy produced a greater reduction in marital burnout than compassion-focused therapy. Furthermore, the difference between the two therapeutic interventions was statistically significant in favor of domestic violence-focused couple therapy.

The Bonferroni results presented in Table 3 also showed that both compassion-focused therapy and domestic violence-focused couple therapy differed significantly from the control group in terms of emotion regulation. The mean difference between the control group and the compassion-focused therapy group was 1.84, whereas the mean difference between the control group and the domestic violence-focused couple therapy group was 2.92. Overall, based on the calculated mean differences, domestic violence-focused couple therapy demonstrated a greater effect on improving emotion regulation than compassion-focused therapy. Accordingly, the effectiveness of the two interventions on emotion regulation differed significantly in favor of domestic violence-focused couple therapy.

4. Discussion

The present study compared the effectiveness of compassion-focused therapy and domestic violence-focused couple therapy in reducing marital burnout and improving emotion regulation among women affected by domestic violence in Dezful. The findings indicated that both interventions produced statistically significant improvements in the two dependent variables compared with the control condition. More specifically, participants who received compassion-focused therapy showed lower posttest marital burnout and higher posttest emotion regulation than those in the control group, while participants who received domestic violence-focused couple therapy likewise demonstrated significant reductions in marital burnout and improvements in emotion regulation. The multivariate analysis showed a significant overall group effect after controlling for pretest scores, and the univariate analyses further confirmed significant intervention effects on both marital burnout and emotion regulation. The effect sizes were substantial, with group membership accounting for a large proportion of the variance in both outcomes. Moreover, Bonferroni-adjusted comparisons showed that domestic violence-focused couple therapy was more effective than compassion-focused therapy in both reducing marital burnout and improving emotion regulation. Thus, although both therapeutic approaches were beneficial, the couple-

based intervention demonstrated a comparatively stronger effect on the outcomes assessed in this study.

The significant effect of compassion-focused therapy on marital burnout can be understood in light of the role of shame, self-criticism, emotional exhaustion, and self-blame in the psychological experiences of women affected by domestic violence. Women who repeatedly experience aggression, coercion, humiliation, or rejection in intimate relationships may gradually internalize negative beliefs about themselves and may come to interpret relational failure as evidence of personal inadequacy. Such processes can intensify emotional depletion and accelerate marital burnout. Compassion-focused therapy directly targets self-criticism and shame by helping individuals develop a more supportive, nonjudgmental, and emotionally soothing relationship with themselves. This interpretation is consistent with the work of Irons and Lad, who emphasized the usefulness of compassion-focused therapy for complex trauma characterized by shame and self-critical processing (Irons & Lad, 2017). It is also aligned with findings showing that low self-compassion, maladaptive trauma appraisals, and emotion regulation difficulties are associated with greater posttraumatic stress symptoms following abuse (Barlow et al., 2017). By reducing self-directed hostility and promoting self-acceptance, compassion-focused therapy may decrease the emotional burden that contributes to marital exhaustion.

The present finding regarding the effect of compassion-focused therapy on marital burnout is also compatible with evidence that compassion-based interventions can improve relational functioning. Shojaei Vazhnany et al. found that compassion-focused therapy improved marital intimacy and emotion regulation among couples, suggesting that compassion-related processes can influence both intrapersonal and interpersonal dimensions of intimate relationships (Shojaei Vazhnany et al., 2020). Although compassion-focused therapy in the present study primarily emphasized the individual emotional experience of women affected by domestic violence, improvements in self-compassion may have helped participants establish healthier boundaries, reduce excessive self-blame, and respond to relational stress with greater psychological stability. These changes may in turn reduce the sense of emotional depletion and helplessness characteristic of marital burnout. In addition, evidence from self-compassion support groups for domestic violence survivors has shown beneficial emotional and cognitive outcomes, reinforcing the view that compassion-oriented interventions may be especially

relevant for women whose experiences of abuse have undermined their sense of safety and personal worth (Allen et al., 2021).

The observed effect of compassion-focused therapy on emotion regulation was likewise expected from a theoretical perspective. Compassion-focused interventions aim to strengthen the soothing and safeness system while reducing overactivation of threat-based emotional responding. In women exposed to domestic violence, emotional experiences such as fear, anger, shame, guilt, and helplessness may become highly reactive because of repeated exposure to threat. Through soothing-rhythm breathing, compassionate imagery, mindful pausing, and development of a compassionate self, participants may become better able to tolerate difficult emotions without resorting to suppression, rumination, or impulsive reactions. The current findings are consistent with previous research showing that compassion-focused interventions can reduce maladaptive emotional responses and enhance psychological adjustment. Grodin et al., for example, found that compassion-focused group therapy had beneficial effects on anger among individuals with posttraumatic stress disorder, indicating that compassion can facilitate more adaptive management of intense affective states (Grodin et al., 2020). Similarly, Baker et al. reported meaningful associations between self-compassion, emotional symptoms, and resilience, suggesting that greater self-compassion may function as an emotional resource under conditions of stress (Baker et al., 2020).

The beneficial effect of compassion-focused therapy on emotion regulation is also consistent with evidence from randomized and brief compassion-based interventions. Krieger et al. showed that a compassion-focused intervention reduced excessive self-criticism and improved relevant psychological outcomes in highly self-critical participants (Krieger et al., 2019). Grey et al. also demonstrated that a brief self-compassion intervention could produce meaningful psychological improvements in a vulnerable population, supporting the broader therapeutic utility of self-compassion-based mechanisms (Grey et al., 2022). In the context of domestic violence, such mechanisms may be particularly important because persistent self-criticism and shame can amplify emotional reactivity and interfere with effective regulation. The present findings are additionally consistent with research indicating that mindfulness-based treatment can reduce experiential avoidance and emotion dysregulation in women exposed to violence (Homayouni et al., 2022). Taken together, these

findings support the conclusion that therapeutic strategies fostering acceptance, emotional awareness, and compassionate self-responding can improve emotion regulation in women affected by domestic violence.

The significant effect of domestic violence-focused couple therapy on marital burnout can be interpreted through its direct focus on relational processes. Marital burnout is not only an intrapersonal state but also an outcome of repeated dysfunctional interaction patterns, unmet emotional needs, escalating conflict, poor communication, and chronic relational insecurity. The couple-based intervention used in the present study directly addressed these processes through safety assessment, responsibility-taking, identification of violence triggers, emotion regulation, conflict de-escalation, reflective listening, nonhostile communication, and discussion of unmet relational needs. This direct targeting of couple-level mechanisms may explain why the intervention produced a particularly strong reduction in marital burnout. Previous research supports this interpretation. Stith et al. emphasized that appropriately adapted interventions for situational couple violence can reduce problematic relational patterns when safety and accountability are explicitly addressed (Stith et al., 2019). Keilholtz and Spencer similarly noted that couple therapy in the context of intimate partner violence can be effective when appropriate assessment, safety procedures, and modality selection are applied (Keilholtz & Spencer, 2022).

The present findings also align with studies showing that restructuring couple interaction patterns can reduce marital distress and burnout. Aghabozorgi et al. reported that couple-based approaches could improve communication patterns and reduce marital burnout among women affected by marital infidelity, supporting the importance of targeting dysfunctional relational processes in the treatment of burnout (Aghabozorgi et al., 2019). Although marital infidelity and domestic violence are distinct experiences, both may involve betrayal, damaged trust, emotional exhaustion, and deterioration in communication. Couple interventions that facilitate more adaptive interaction and clarify relational needs may therefore reduce the cumulative emotional burden associated with marital burnout. Babaei et al. further demonstrated the relevance of social-cognitive and executive processes to marital burnout, suggesting that the way partners interpret one another's internal states can affect the severity of relational exhaustion (Babaei et al., 2024). From this perspective, communication restructuring and reflective listening may reduce misinterpretations and

defensive responding and thus weaken patterns that maintain burnout.

The effect of domestic violence-focused couple therapy on emotion regulation can also be understood through the reciprocal relationship between interpersonal conflict and emotional arousal. Violent relationships are often characterized by rapid escalation, heightened physiological activation, hostile attribution, impulsive responding, and poor recovery after conflict. By helping participants identify triggers, recognize the cycle of violence, use time-out strategies, practice relaxation, and engage in structured nonhostile communication, the intervention likely reduced the frequency and intensity of emotionally dysregulating interactions. This interpretation is compatible with the findings of Homayooni et al., who showed that a couple therapy approach could improve psychological flexibility, cognitive emotion regulation, and communication patterns (Homayooni et al., 2023). It also corresponds with evidence that emotion-focused therapy can improve emotion regulation among women affected by domestic violence (Moeini et al., 2022). In both cases, the findings suggest that changes in emotional functioning can emerge when interventions modify not only internal emotional processes but also the interpersonal context in which emotional responses are activated.

The present findings are also consistent with the literature on emotion-focused and violence-sensitive couple interventions. Slootmaeckers and Migerode described the use of emotionally focused therapy in intimate partner violence with an emphasis on de-escalating violent interaction cycles and restructuring maladaptive relational patterns (Slootmaeckers & Migerode, 2020). This conceptualization is highly relevant to the current findings because reducing escalation can lower emotional arousal and provide a safer context for expressing needs and emotions. Fedynich et al. likewise demonstrated the applicability of conjoint cognitive-behavioral treatment in a complex relational context involving trauma and domestic violence, highlighting the potential value of structured, trauma-informed couple interventions (Fedynich et al., 2021). Furthermore, narrative therapy has been shown to improve communication, emotional expression, and empathy among couples, suggesting that relational interventions can enhance the emotional competencies needed for healthier couple functioning (Boostani-Kashani et al., 2021). Together, these studies support the view that improving the quality of interaction may contribute directly to better emotion regulation.

Another important finding was the greater effectiveness of domestic violence-focused couple therapy compared with compassion-focused therapy on marital burnout. This difference is theoretically plausible because marital burnout is fundamentally embedded in the marital relationship and is sustained by recurring dyadic patterns. Compassion-focused therapy may reduce personal suffering and improve the participant's internal emotional response, but it does not necessarily modify the behavior of the partner or the interactional sequences that contribute to exhaustion. In contrast, domestic violence-focused couple therapy directly addresses conflict cycles, responsibility, communication, relational expectations, safety, and unmet needs. Consequently, it may influence the proximal mechanisms maintaining marital burnout more directly. This interpretation is consistent with findings that couple-based interventions can improve intimacy, commitment, communication, and adjustment (Beheshtinejad et al., 2022). It is also compatible with predictive research showing that marital burnout is related to emotional intelligence, mental health, resilience, and differentiation of self (Mahdigholi et al., 2022), because couple therapy can potentially strengthen relational coping while also promoting emotional and cognitive flexibility within the interaction itself.

The greater effect of domestic violence-focused couple therapy on emotion regulation may initially appear less obvious, because compassion-focused therapy explicitly targets emotional soothing and regulation. However, in the context of ongoing or recent domestic violence, emotional dysregulation may be strongly maintained by relational triggers rather than only by intrapersonal vulnerabilities. When conflict escalation, fear, withdrawal, blame, and hostile exchanges are reduced, the frequency of intense emotional activation may also decrease. Couple-based work can therefore improve emotion regulation indirectly by modifying the environment in which dysregulation occurs. The significant comparative advantage observed in the present study may reflect the combined effects of explicit emotion-regulation training and simultaneous restructuring of interpersonal triggers. This interpretation is supported by evidence that emotion-focused therapy improves assertiveness and reduces anger rumination in women affected by domestic violence (Leshani, 2023). It is also consistent with the finding that emotional intelligence and emotional expressiveness are related to hopelessness among women experiencing domestic violence, demonstrating that emotional processing is deeply connected to interpersonal and psychological adjustment (Hervika et al., 2021).

The findings also fit within a broader body of literature indicating that women exposed to domestic violence benefit from interventions that address multiple levels of functioning. Özkafacı and Eren found that art psychotherapy reduced depression, anxiety, and hopelessness among female survivors of domestic violence with posttraumatic stress disorder, showing that therapeutic approaches that facilitate emotional processing may support recovery from violence-related distress (Özkafacı & Eren, 2020). Similarly, Taghipour reported the usefulness of acceptance and commitment therapy for alexithymia and personal values among women victims of domestic violence, further emphasizing the value of interventions that increase emotional awareness and psychological flexibility (Taghipour, 2026). These studies, together with the present findings, suggest that domestic violence affects a network of emotional, cognitive, and relational processes and that effective treatment should ideally target several of these domains.

The current findings may also be interpreted in light of the broader psychosocial consequences of domestic violence. Raifman et al. demonstrated that domestic violence is associated with important dimensions of women's reproductive and family lives, illustrating that its consequences extend beyond isolated psychological symptoms (Raifman et al., 2021). Gulati and Kelly similarly emphasized the mental health implications of violence against women during periods of heightened social stress, underscoring the need for accessible psychiatric and psychological responses (Gulati & Kelly, 2020). Domestic violence therefore represents a context in which individual emotional vulnerabilities and relationship-level stressors are mutually reinforcing. In such circumstances, compassion-focused therapy may strengthen internal coping and reduce self-directed suffering, whereas domestic violence-focused couple therapy may additionally alter the relational conditions that perpetuate emotional exhaustion and dysregulation.

The results regarding marital burnout are also compatible with research indicating that maladaptive relational attitudes and marital adjustment are associated with burnout. Nikmanesh and Amiri Moghadam reported associations among attitudes toward infidelity, marital burnout, and marital maladjustment (Nikmanesh & Amiri Moghadam, 2020). Likewise, Ghasemi et al. showed that marital burnout was associated with mental health-related variables in women affected by infidelity (Ghasemi et al., 2023). These findings reinforce the idea that marital burnout reflects a

broader process of relational and psychological depletion. The reduction in burnout observed in the current study may therefore represent not merely lower dissatisfaction but a wider improvement in participants' emotional engagement, sense of control, and ability to cope with marital stress.

5. Conclusion

Overall, the present study supports the effectiveness of both compassion-focused therapy and domestic violence-focused couple therapy for women affected by domestic violence. The findings suggest that compassion-focused therapy may be especially useful for reducing self-criticism, shame, and emotional distress and for strengthening adaptive emotion regulation, whereas domestic violence-focused couple therapy may exert additional benefits by directly restructuring the interpersonal processes that maintain marital burnout and emotional dysregulation. The stronger effects observed for the couple-based intervention should nevertheless be interpreted within the context of appropriate safety screening and careful clinical selection. Couple therapy in situations involving intimate partner violence is not universally appropriate, and conjoint treatment must be avoided when coercive control, severe fear, ongoing high-risk violence, or safety concerns make participation unsafe. Within appropriately selected cases, however, the present results indicate that a violence-sensitive couple intervention may offer substantial benefits for both relational and emotional outcomes.

Several limitations should be considered when interpreting the findings of the present study. First, the sample consisted of only 45 women recruited from two psychological centers in Dezful, which limits the generalizability of the findings to women from other regions, cultural contexts, socioeconomic backgrounds, or treatment settings. Second, convenience sampling may have introduced selection bias, because women who sought psychological services and agreed to participate may differ systematically from women experiencing domestic violence who do not seek treatment. Third, the study relied primarily on self-report questionnaires, and responses may have been influenced by social desirability, recall bias, or participants' emotional state at the time of assessment. Fourth, the study used only pretest and posttest measurements and did not include a follow-up assessment; therefore, the durability of the treatment effects cannot be determined. Fifth, the relatively small group sizes may limit the precision of effect estimates. Sixth, domestic violence is heterogeneous in type,

severity, chronicity, and degree of coercive control, yet these dimensions were not analyzed separately. Finally, because one intervention was individual or self-focused in orientation and the other was couple-based, differences in therapeutic format, relational involvement, number of sessions, and total treatment exposure may have contributed to the observed between-treatment differences.

Future studies are recommended to replicate these findings using larger, more diverse, and multisite samples and to employ probability-based sampling methods where feasible. Researchers should include follow-up assessments over several months to determine whether improvements in marital burnout and emotion regulation are maintained after treatment termination. Future research could also stratify participants according to the type and severity of domestic violence, the presence of coercive control, duration of abuse, trauma symptom severity, and relationship status in order to identify which subgroups benefit most from each intervention. Comparative studies should attempt to equalize treatment dose and session number across conditions to permit a more rigorous comparison of intervention effects. Including clinician-rated measures, behavioral observations, partner reports where ethically appropriate, and physiological indicators of emotional arousal could also strengthen the validity of findings. Future studies may additionally examine mediating mechanisms such as self-compassion, shame, experiential avoidance, communication patterns, perceived safety, and cognitive reappraisal, as well as potential moderators including age, education, duration of marriage, socioeconomic status, and prior treatment history. It would also be valuable to compare integrated interventions combining compassion-focused techniques with violence-sensitive couple therapy against each treatment alone.

The findings suggest that clinicians working with women affected by domestic violence should assess both intrapersonal emotional difficulties and relationship-level processes rather than treating marital burnout or emotion dysregulation as isolated symptoms. Compassion-focused strategies may be incorporated when shame, self-blame, self-criticism, or difficulty tolerating painful emotions are prominent. In cases where conjoint treatment is clinically appropriate and safety has been carefully established, domestic violence-focused couple therapy may be used to address escalation patterns, responsibility for violence, communication deficits, unmet relational needs, and emotion-regulation difficulties. Practitioners should conduct systematic risk assessments before and throughout any couple-based intervention and should prioritize the safety

and autonomy of the victim over preservation of the relationship. Psychological centers serving women affected by domestic violence may also benefit from developing stepped-care protocols in which individual stabilization, safety planning, compassion-based work, and couple intervention are offered according to the characteristics and risks of each case. Training clinicians in trauma-informed, violence-sensitive, and compassion-based practice may further improve the quality and safety of psychological services provided to this population.

Authors' Contributions

Authors equally contributed to this article.

Declaration

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

Transparency Statement

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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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