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Comparing Mentalizing and Transdiagnostic Therapies for Distress Tolerance in Religiously Committed Betrayed Women

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ABSTRACT

Objective: The aim of this study was to compare the effectiveness of Mentalizing Process Therapy and Integrative Transdiagnostic Therapy on distress tolerance in religiously committed women who had experienced betrayal.

Methods: This study was applied in purpose and employed a quasi-experimental design with pre-test and post-test and a control group. The sample included 45 religiously committed women who had experienced spousal betrayal, diagnosed by psychologists at counseling centers in Shiraz (Segal, Afagh, and Avaye Mehr). Participants were selected through convenience sampling and randomly assigned to three groups of 15 (two experimental groups and one control group). One experimental group received Mentalizing Process Therapy, the second received Integrative Transdiagnostic Therapy, and the control group received no intervention. Data were collected using the Distress Tolerance Scale and analyzed with SPSS through descriptive statistics and analysis of covariance.

Results: Both Mentalizing Process Therapy and Integrative Transdiagnostic Therapy significantly improved distress tolerance in religiously committed betrayed women compared to the control group. However, no significant difference was found between the effectiveness of the two therapeutic approaches.

Conclusions: The findings indicate that both therapeutic methods can be effective in enhancing distress tolerance among religiously committed women facing betrayal. Nevertheless, neither approach showed superiority over the other.

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Introduction

Infidelity can inflict severe emotional trauma on couples. Psychotherapists report that betrayed spouses often experience emotions such as anger, low self-esteem, humiliation, depression, and helplessness (Astuti & Lestari, 2022). Unfaithful spouses, on the other hand, grapple with feelings of shame, guilt, doubt, anger, and hopelessness. The intense emotional turmoil following the disclosure of marital infidelity is frequently accompanied by cognitive distress. Any form of secrecy from one's spouse or engagement outside the marital framework is considered a breach of fidelity (Song & Nadarajah, 2022).

Infidelity against women is recognized as a form of gender-based violence, adversely affecting all dimensions of health and fundamentally destabilizing the family structure. It leads to numerous challenges in marital and parent-child relationships (Boyce et al., 2016). For instance, Asadyan and Sadaghat (2014), in their study on factors contributing to emotional divorce due to marital infidelity among couples, found a significant correlation between extramarital tendencies and emotional divorce. Although infidelity diverts the betrayer's attention to an extramarital affair, they may not necessarily seek separation or divorce. Consequently, the betrayed spouse faces two options: ending the relationship or forgiving the transgressor and navigating the ensuing marital distress, which may precipitate severe psychological complications (Aghili & Kashiri, 2022). In this context, examining distress tolerance becomes imperative.

Research has also highlighted the role of distress tolerance in post-infidelity adjustment. For example, Zakerzadeh (2022), in a study on the relationship between mindfulness, meta-emotions, and distress tolerance—mediated by psychological capital in betrayed women—emphasized the pivotal role of distress tolerance. Psychological distress manifests through symptoms such as low mood, anxiety, depression, and other psychiatric conditions. It reflects a state of emotional suffering linked to life stressors, where individuals lack healthy coping mechanisms, encompassing depression, anxiety, and stress (Stein et al., 2021). Elevated psychological distress correlates with exacerbated symptoms and a higher risk of mental illness, often leading to maladaptive coping strategies, such as emotional detachment in marital relationships and familial dysfunction. Symptoms include impaired concentration—a transient yet disruptive experience (Aghili & Kashiri, 2022). Distress tolerance refers to an individual's capacity to endure psychological distress. Those with low distress tolerance perceive emotions as overwhelming, lack

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coping skills, and may deny or exacerbate their distress (Soleymani et al., 2020). Such individuals often engage in maladaptive behaviors to suppress emotions, which provide only temporary relief (Stein et al., 2021).

Some studies suggest that individuals with higher religious adherence exhibit greater awareness and acceptance of personal challenges. For instance, Mousavi et al. (2018) noted that religious individuals demonstrate stronger commitment and adaptability in coping with life adversities—a finding widely acknowledged in Iran. However, selecting the most effective intervention remains critical.

While various therapies have been employed to improve marital adjustment, identifying the optimal treatment is essential for sustained efficacy. Addressing the limitations of cognitive-behavioral approaches, experts have proposed transdiagnostic interventions, such as the Unified Protocol (UP) for Emotional Disorders, which employs a single therapeutic protocol for diverse conditions (Barlow et al., 2020). Among transdiagnostic frameworks, Barlow's UP has shown particular efficacy for emotional disorders and emotional divorce (Barlow et al., 2020). This cognitive-behavioral approach targets emotional dysregulation, emphasizing adaptive emotional processing (Akbari et al., 2015). It facilitates emotional awareness and reduces maladaptive coping strategies, thereby mitigating psychological distress (Fairburn et al., 2009).

The UP identifies cognitive distortions and emotional avoidance through metacognitive assessment, fostering insight and functional restructuring (Wise et al., 2023). It effectively alleviates mood and anxiety disorders by enhancing emotional recovery and preventing symptom escalation (Schaeuffele et al., 2022). Compared to classical cognitive-behavioral therapies, the UP demonstrates superior outcomes for transdiagnostic symptoms, such as psychological exhaustion and loneliness (Timulak et al., 2022). By addressing maladaptive emotional responses, it reduces cognitive instability and reinforces constructive beliefs (Akbari et al., 2015).

Another intervention, Mentalization-Based Therapy (MBT), rooted in Bowlby's attachment theory, focuses on developmental vulnerabilities (Tahmasebiashtiani et al., 2022). Initially designed for borderline personality disorder and attachment-related pathologies, MBT has expanded to address broader emotional dysregulation (Krämer et al., 2021; Malda-Castillo et al., 2019). It operates on four principles: self-other differentiation, emotion-cognition balance, internal-external world distinction, and controlled-automatic mentalization. MBT aims to integrate

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fragmented self-representations, reducing projective identification and fostering balanced emotional-cognitive processing. Empirical studies confirm its efficacy in improving cognitive-affective functioning (Daubney & Bateman, 2015; Krämer et al., 2021). Given these findings, this study examines whether MBT and UP differentially improve distress tolerance in religiously adherent betrayed women.

Material and Methods

This study was an applied research project employing a quasi-experimental design with pre-test and post-test measures, including a control group. The statistical population consisted of all women who sought counseling services in Shiraz in 2023 due to marital conflicts. Based on Delavar's (2006) recommendation for quasi-experimental studies, a sample size of 15 participants per group was deemed sufficient to yield statistically valid results. Thus, the study sample comprised 45 religiously adherent women who had experienced spousal infidelity, as diagnosed by psychologists at counseling centers in Shiraz (Segal, Afagh, and Avaye Mehr Counseling Centers). Participants were selected via convenience sampling and randomly assigned to three groups (15 per group): Experimental Group 1: Received Mentalization-Based Therapy (MBT), Experimental Group 2: Received Unified Protocol (UP) for Transdiagnostic Treatment and Control Group: Received no intervention.

Inclusion criteria include residency in Shiraz, religious adherence, minimum of four years of marriage, willingness to provide informed consent and absence of severe physical or psychological disorders (assessed via initial screening). Exclusion criteria include incomplete responses to questionnaires, unwillingness to continue participation and concurrent participation in other interventions.

Measurements

Distress Tolerance Scale (DTS): DTS is a 15-item self-report questionnaire assessing emotional distress tolerance across four subscales (Simons & Gaher, 2005), tolerance (emotional distress endurance; items 1, 3, 5), absorption (preoccupation with negative emotions; items 2, 4, 15), appraisal (subjective distress evaluation; items 6, 7, 9–12) and regulation (efforts to alleviate distress; items 8, 13, 14). Items were scored on a 5-point Likert scale (1 = *Strongly Agree* to 5 = *Strongly Disagree*), with item 6 reverse-scored. Higher scores indicated greater distress

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tolerance. Simons and Gaher (2005) reported Cronbach's alpha coefficients of 0.72 (Tolerance), 0.82 (Absorption), 0.78 (Appraisal), 0.70 (Regulation), and 0.82 for the full scale. Alavi et al. (2016) validated the scale among Iranian students, reporting internal consistency of 0.71 (full scale) and moderate subscale reliabilities (Tolerance: 0.54; Absorption: 0.42; Appraisal: 0.56; Regulation: 0.58).

Procedure

The researcher obtained approval from Qeshm Branch, Islamic Azad University, to access counseling centers. Eligible participants (N = 45) were selected via convenience sampling and randomly assigned to MBT, UP, or control groups. Experimental groups received their respective interventions (detailed in Table 1 and 2), while the control group received no treatment. Data were analyzed using SPSS-26.

Therapeutic Protocols

Table 1 summarizes the Mentalization-Based Therapy (MBT) sessions and table 2 summarizes transdiagnostic therapy sessions.

Table 1. Summary of MBT sessions

Session	Aim	Content
1	What is mentalization and the mentalization position?	Statement of the goals of the group sessions, emphasis on active participation in the group, introduction of the group members and why they were referred for treatment? Explanation of specific aspects, dimensions and benefits of mentalization and its distinction from misinterpretations by the therapist, presentation of homework.
2	What is the problem with mentalization?	Statement of the goals of the session, indicators of poor and good mentalization, problems in mind-reading oneself and others, problems with emotion regulation and impulsivity, interpersonal sensitivity, clarification of participants, presentation of homework.
3	Why do we have emotions and what are the main emotions?	Statement of the goals of the session, main and social emotion, primary and secondary emotions), description of types of emotions and individual differences in controlling emotions, presentation of homework.
4	Mentalization of emotions	Statement of the goals of the session, how to deal with emotions and feelings, interpretation of internal emotional signals in oneself and others, self-regulation of emotions and how others can help regulate our emotions, non-mentalized emotions that are very uncomfortable and how to manage them, presentation of relaxation methods, presentation of homework.
5	The importance of attachment relationships	Statement of session goals, discussion of attachment and attachment strategies in adulthood, assignment of homework.
6	Attachment and mentalization	Statement of session goals, attachment conflicts, and assignment of homework.
7	Mentalization-based therapy	Statement of session goals, mentalization-based therapy, statement of specific and specific goals of MPT, training and practice of mentalization in the group, assignment of homework.
8	Mentalization-based therapy	Statement of session goals, importance of establishing connections with others and establishing attachment relationships with the therapist and other group members, assignment of homework.

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9	Anxiety, attachment and mentalization	Statement of session goals, providing education about anxiety and fear, stating types of anxiety disorders and their treatment strategies, and that the help of another person is a key component in treatment, assignment of homework.
10	Depression, attachment and mentalization	Statement of session goals, providing an educational approach to depression, providing education about the course and treatment of depression, discussion of depressive thinking, assignment of homework.
11	_	Summary and conclusion
12	Empathic support and validation	Review of previous group discussion, statement of group meeting goals, asking group members about problems they want to address in the group, empathetic affirmation.
13-14	Clarify	Clarification of the issues raised by the group members by the therapist, synthesis of problems, exploration of problems and, if necessary, challenging.
15-16	Emotional identification and focus	Identifying and focusing emotionally on the issues raised by the group members.
17	_	Training in mentalizing the material to facilitate epistemic trust.
18-19	Mentalization and communication	Mentalizing the relationship with regard to transference markers.
20	–	Preparing for the end of therapy, focusing on the feeling of loss in the context of the end of therapy, ending therapy.

Table 2. Summary of Integrative Transdiagnostic Therapy Sessions

Session	Aim	Content
1	Increasing motivation to participate in treatment	Increase patients' readiness and motivation for behavioral change and strengthen self-efficacy through belief in one's own ability to successfully achieve the desired change.
2	Psychological education and emotional experience seeking	Psychoeducation about the nature of emotions, the main components of emotional experience, and the concept of learned responses.
3	Emotional awareness training	Identifying how one reacts and responds to emotions, non-judgmental and present-centered awareness in emotional experience.
4	Cognitive appraisal and reappraisal	Identifying the role of maladaptive automatic evaluations in creating emotional experiences, identifying one's own thinking patterns and methods for correcting maladaptive thinking.
5	Emotional avoidance and emotion-induced behaviors	Identifying emotional patterns and maladaptive behaviors caused by emotion, being aware of how behaviors affect the continuation of discomfort, trying to change current patterns of emotional responses.
6	Awareness of and tolerance for bodily sensations	Increasing awareness of the role of bodily sensations along with emotional experiences.
7	Endogenous and situation-based emotional coping	Emphasis on internal and external triggers of emotion, increasing tolerance to them, and learning new contexts.
8	Relapse prevention	Reviewing therapeutic concepts and discussing treatment progress, anticipating potential problems and how to deal with them, and encouraging and encouraging the continuation of the methods taught.

Results

Data were analyzed using SPSS software (Version 26). Both descriptive and inferential statistical methods were applied. Descriptive indicators of the study variables were examined through measures such as mean and standard deviation, while inferential analyses were conducted using analysis of covariance (ANCOVA) to test the research hypotheses.

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Table 3 presents the descriptive statistics (mean and standard deviation) of distress tolerance scores across two measurement points (pretest and posttest) for the control group, the mentalization-based intervention group, and the integrated transdiagnostic treatment group.

Table 3. Descriptive statistics of distress tolerance scores across pretest and posttest for all groups

Group	Variable	Pretest		Posttest	
		Mean	SD	Mean	SD
Control	Tolerance	7.80	3.098	8.27	3.173
	Absorption	7.47	2.900	7.87	2.167
	Appraisal	11.43	3.461	11.90	2.878
	Regulation	6.87	2.615	7.33	2.093
	Distress tolerance	33.57	6.929	35.37	8.123
Integrated transdiagnostic	Tolerance	9.33	3.039	11.40	3.112
	Absorption	7.67	3.716	9.73	3.826
	Appraisal	10.97	4.415	12.90	4.243
	Regulation	7.13	2.503	9.60	2.947
	Distress tolerance	35.10	7.469	43.63	7.624
MBT	Tolerance	8.27	3.105	11.27	3.058
	Absorption	7.60	2.586	10.53	2.850
	Appraisal	10.70	3.913	13.32	3.660
	Regulation	7.27	2.344	10.47	2.386
	Distress tolerance	33.84	7.601	45.59	7.381

As shown, the control group demonstrated little change in distress tolerance scores from pretest to posttest. In contrast, both experimental groups exhibited higher posttest scores compared with pretest scores, indicating improvement in distress tolerance following the interventions.

To compare the effectiveness of the mentalization-based intervention and the integrated transdiagnostic treatment on distress tolerance among religious women experiencing infidelity, a multivariate analysis of covariance (MANCOVA) was conducted. All assumptions for MANCOVA were met, confirming the appropriateness of the analysis.

Table 4 presents the results of the multivariate analysis of covariance comparing distress tolerance between the experimental and control groups.

Table 4. Results of the multivariate analysis of covariance

Effect	Test	Value	F	Effect DF	Error DF	P	Effect size
Group	Pillai's Trace	0.799	5.983	8	72	0.001	0.399
	Wilks' Lambda	0.213	10.194	8	70	0.001	0.538
	Hotelling's Trace	3.631	15.433	8	68	0.001	0.645
	Roy's Largest Root	3.616	32.541	4	36	0.001	0.783

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The multivariate test statistics (Pillai's Trace, Wilks' Lambda, Hotelling's Trace, and Roy's Largest Root) were all significant at the 0.01 level ($p < .01$), indicating that posttest distress tolerance scores significantly differed between groups.

To further investigate differences in the components of distress tolerance, the between-subjects effects test was applied.

Table 5. Between-subjects effects test results

Variable	Source	SS	DF	MS	F	P	Effect size
Tolerance	Between group	50.661	2	25.331	20.640	0.001	0.521
	Error	46.635	38	1.227			
Absorption	Between group	50.824	2	25.412	14.073	0.001	0.426
	Error	68.619	38	1.806			
Appraisal	Between group	28.509	2	14.254	15.589	0.001	0.451
	Error	34.746	38	0.914			
Regulation	Between group	60.953	2	30.477	20.840	0.001	0.523
	Error	55.570	38	1.462			

As shown in Table 5, the obtained F-values for all four components were statistically significant at the 0.01 level ($p < .01$). This result indicates that the mean posttest scores of distress tolerance components significantly differed across the control, integrated transdiagnostic, and mentalization-based intervention groups. Pairwise comparisons of the groups were conducted using the Bonferroni post hoc test, the results of which are reported in Table 6.

Table 6. Bonferroni post hoc test results

Variable	Group	Group	Mean difference	Std. error	P
Tolerance	Control	Integrated transdiagnostic	-1.729	0.418	0.001
		MBT	-2.592	0.409	0.001
	Integrated transdiagnostic	MBT	-0.863	0.409	0.125
Absorption	Control	Integrated transdiagnostic	-1.730	0.507	0.005
		MBT	-2.597	0.496	0.001
	Integrated transdiagnostic	MBT	-0.867	0.496	0.266
Appraisal	Control	Integrated transdiagnostic	-1.184	0.360	0.007
		MBT	-1.963	0.353	0.001
	Integrated transdiagnostic	MBT	-0.779	0.353	0.101
Regulation	Control	Integrated transdiagnostic	-2.118	0.456	0.001
		MBT	-2.780	0.447	0.001
	Integrated transdiagnostic	MBT	-0.661	0.447	0.440

Findings revealed that both the unified transdiagnostic treatment and the mentalization-based intervention significantly improved distress tolerance compared to the control group. However, no significant difference was observed between the two experimental groups in terms of effectiveness.

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Discussion

The findings of this study indicated that both the Unified Transdiagnostic Treatment and the Mentalization-Based Therapy were effective in enhancing distress tolerance among religious women who had experienced marital infidelity. However, no significant difference was observed between the two approaches in terms of their effectiveness.

The significant effects of both treatments on distress tolerance and the absence of significant differences between them are consistent with the findings of previous studies (Aghili & Kashiri, 2022; Basharpoor & Einy, 2020; Sharifi et al., 2020; Soleymani et al., 2020; Tahmasebiashtiani et al., 2022; Zakerzadeh, 2022).

Experiencing marital infidelity is among the most painful interpersonal challenges, and coping with it is highly difficult (Krämer et al., 2021). Enhancing distress tolerance in women who have been victims of infidelity can facilitate their adaptation, reduce the risk of marital breakdown, and promote psychological recovery.

Within the framework of mentalization-based therapy, the intervention focused on participants' internal interpretations of their emotional, behavioral, and relational experiences (Mousavi et al., 2018). By recognizing and reconstructing negative and rigid interpretations related to emotional distress, participants gradually developed more adaptive perspectives, which in turn increased their tolerance of distress. This finding aligns with Tahmasebiashtiani et al. (2022), who highlighted that shifting negative interpretations toward constructive ones plays a crucial role in improving psychological well-being and resilience.

Furthermore, mentalization-based therapy addressed attachment-related needs such as attention, approval, trust, and availability, which are fundamental to psychological security (Mousavi et al., 2018). By facilitating dialogue around these unmet needs, participants were able to re-establish secure relational bonds, which improved their psychological safety and resilience to distress. These outcomes support Basharpoor and Einy (2020), who argued that fulfilling attachment needs contributes significantly to mental health and coping capacity.

Similarly, the Unified Transdiagnostic Treatment proved effective in strengthening distress tolerance. This approach emphasized emotional awareness, helping participants recognize their positive and negative emotions and understand the maladaptive consequences of suppressing or over-engaging with negative emotions. Through constructive emotional expression, participants reduced internal tension and increased their capacity to tolerate distress. These findings are consistent with Sadeghi et al.

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(2020), who reported that enhancing emotional regulation leads to improved psychological security and resilience.

Additionally, cognitive reappraisal was central in the Unified Transdiagnostic Treatment. By identifying and restructuring maladaptive beliefs, participants were able to diminish the destructive impact of negative cognitions and adapt more effectively to stressful life conditions. This aligns with Soleymani et al. (2020), who emphasized the corrective role of cognitive restructuring in restoring psychological safety and improving adaptability.

Taken together, both therapeutic approaches—by targeting emotional regulation, cognitive restructuring, and interpretive flexibility—proved to be comprehensive frameworks for enhancing distress tolerance in women facing the traumatic experience of marital infidelity. Their comparable effectiveness may be attributed to their shared focus on strengthening emotional and cognitive systems, thereby enabling participants to adapt more constructively to distressing experiences.

This study is not without limitations. First, the research was conducted on a relatively small and specific sample of religious women who had experienced marital infidelity, which restricts the generalizability of the findings to wider populations. Second, the reliance on self-report questionnaires may have introduced response bias, as participants could underreport or exaggerate their levels of distress. Third, the study focused only on short-term outcomes measured immediately after the intervention, leaving the long-term stability of the therapeutic effects uncertain. Finally, cultural and religious factors surrounding marital infidelity may have influenced participants' responses, making the findings context-dependent.

Future studies should aim to address these limitations by recruiting larger and more diverse samples, including both men and women from various cultural and religious backgrounds, in order to improve the external validity of the results. Longitudinal designs are recommended to evaluate the durability of treatment outcomes over time. Researchers should also consider incorporating objective behavioral or physiological indicators alongside self-reports for more robust assessments. In practice, clinicians are encouraged to integrate both the Unified Transdiagnostic Treatment and Mentalization-Based Therapy, as they complement each other in targeting emotional regulation, cognitive restructuring, and attachment needs. Developing culturally sensitive adaptations of these interventions would further enhance their applicability and effectiveness in non-Western populations.

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Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Ethics statement

The studies involving human participants were reviewed and approved by the ethics committee of Islamic Azad University. The patients/participants provided their written informed consent to participate in this study.

Author contributions

S. F.S.N., M.J.P. and K.S. contributed to the study conception and design, material preparation, data collection, and analysis. All authors contributed to the article and approved the submitted version.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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