

INTERPERSONAL CONFLICT AND PSYCHOLOGICAL TRAUMA: IMPLICATIONS FOR CONFLICT MANAGEMENT AND TRAUMA-INFORMED INTERVENTIONS

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Relationships with others are essential for our psychological well-being. They offer support, make us feel truly seen and understood, and give us a sense of belonging. However, serious conflicts can completely disrupt this balance, reactivating deep traumas and leaving lasting emotional scars as well as difficulties in maintaining healthy connections. When handle tensions in a mature and constructive way, the likelihood of them turning into something traumatic drops significantly. Unhealthy patterns, such as avoiding conversations, passive-aggressive behavior, silent treatment, or unnecessary escalation, greatly increase our vulnerability to serious psychological issues, including post-traumatic stress. Recent research clearly shows a bidirectional relationship: poorly managed or unresolved conflicts can trigger or intensify trauma, while people who already carry unresolved trauma from the past often struggle greatly to resolve new conflicts, which in turn makes them more susceptible to repeated victimization. This article reviews the most relevant publications from the past year on this topic. It focuses especially on practical strategies for handling relationships during conflict and on the psychological consequences of interpersonal trauma, highlighting interventions that are supported by solid scientific evidence.

Key words: *conflict, trauma, stress, management, therapy*

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1. INTRODUCTION

Relationships with others represent a fundamental pillar of psychological well-being. They provide emotional support, foster a sense of being understood and validated, and cultivate feelings of belonging and social connectedness.

The present article synthesizes recent empirical literature examining the interplay between interpersonal conflict and psychological trauma. When these relationships become sources of intense, recurrent conflict or sustained interpersonal tension, they can profoundly disrupt psychological equilibrium. Such circumstances may precipitate significant traumatic responses, resulting in enduring emotional sequelae and impairments in the capacity to sustain healthy interpersonal connections.

The particular emphasis is placed on the bidirectional nature of this relationship: poorly managed or unresolved conflicts can precipitate or intensify traumatic responses, while pre-existing trauma, particularly interpersonal trauma originating in childhood or prior intimate relationships, impairs constructive conflict resolution, thereby perpetuating cycles of revictimization and relational deterioration.

Conflicts arising in various relational contexts, as romantic partnerships, family systems, workplaces, or communities, elevate emotional stress to clinically significant levels. These stressors extend beyond transient distress and can precipitate or exacerbate conditions such as posttraumatic stress disorder (PTSD), severe anxiety, major depressive disorder, or persistent difficulties in forming and maintaining adaptive relationships [19].

Interpersonal trauma refers to experiences in which harm is intentionally inflicted by another person. This includes emotional, physical, or sexual abuse; domestic violence; persistent harassment. Repeated victimization within close relationships; and trauma occurring in contexts of armed conflict or interpersonal violence [21].

Unlike non-interpersonal traumatic events as accidents, natural disasters, those perpetrated by others typically produce deeper and more persistent psychological wounds. They undermine core aspects of self-concept, trust in others, and emotional regulation, thereby establishing a self-perpetuating cycle: initial trauma increases vulnerability, which in turn heightens exposure to subsequent harm.

The discussion encompasses

risk and protective factors identified in longitudinal studies, which demonstrate how certain patterns of conflict management either exacerbate vulnerability or mitigate traumatic impact. Subsequently, evidence-based interventions are reviewed, focusing on approaches that simultaneously reduce posttraumatic symptoms and facilitate relational repair.

The overarching premise is that effective responses require an integrated framework combining prevention, symptom-focused treatment, and relational reconstruction. Such multilevel strategies are essential to alleviate the individual psychological burden and mitigate broader societal impacts associated with cycles of interpersonal trauma and conflict.

2. SCIENTIFIC APPROACH TO CONFLICT SITUATIONS

The management of interpersonal relationships during conflict represents a critical factor in both preventing the onset of trauma and mitigating its impact when trauma has already occurred. Constructive conflict management approaches, characterized by open communication, collaboration, and effective emotional regulation, substantially reduce the potential for

traumatic outcomes.

Conversely, dysfunctional styles such as avoidance, passive-aggressive behavior, or indirect aggression tend to exacerbate feelings of isolation, shame, and chronic hypervigilance. Contemporary clinical guidelines advocate for integrated interventions that address both posttraumatic stress disorder (PTSD) symptoms and relational difficulties concurrently, thereby facilitating trust restoration and reducing the risk of revictimization.

Conflict management style directly influences psychological outcomes. Combinations involving passive-aggressive (indirect) strategies paired with acquiescence (low assertiveness and high yielding) are associated with elevated anxiety, whereas indirect aggression combined with low collaboration correlates with increased depressive symptoms. In contrast, constructive approaches emphasizing direct communication and integrative problem-solving protect relational quality and diminish emotional distress.

Recent empirical work underscores a robust bidirectional relationship between interpersonal conflict and trauma. Unresolved or maladaptively managed conflicts, through avoidance, passive-aggression, or escalation, increase the

probability of repeated victimization and the development or worsening of PTSD symptoms.

Reciprocally, individuals with a history of interpersonal trauma, particularly from childhood or intimate relationships, exhibit impaired capacity for constructive conflict resolution, thereby perpetuating cycles of revictimization and progressive relational deterioration.

Longitudinal studies consistently indicate that the overall severity of PTSD symptoms serves as a reliable predictor of subsequent interpersonal revictimization, establishing a vicious cycle in which posttraumatic symptomatology heightens relational vulnerability. Interpersonal traumas, including those arising from domestic violence, emotional abuse, or exposure to armed conflict, produce more severe psychological consequences than non-interpersonal events.

Elevated rates of PTSD, anxiety disorders, and broader social dysfunction are commonly reported in these contexts. Empirical findings indicate that relational forms of trauma, such as sexual or physical violence within intimate partnerships, carry a PTSD risk comparable in magnitude to that observed in war-related trauma, highlighting the pivotal role of relational dynamics

in the etiology and persistence of psychological distress.

Among emerging adults, forgiveness functions as a significant protective mechanism in the context of recurrent interpersonal conflict. Given that conflict is inevitable in relationships, the manner of its management profoundly influences mental health, relational quality, and daily functioning at both individual and group levels [4].

Contemporary research, drawing on established frameworks such as the Thomas-Kilmann model and the dual concern model (assertiveness versus cooperativeness), delineates five primary conflict styles: competing (high assertiveness, low cooperativeness), accommodating (low assertiveness, high cooperativeness), avoiding (low on both dimensions), compromising (moderate on both), and collaborating (high on both) [8].

A nationally representative Swiss study conducted in the post-COVID period investigated associations between perceived conflict styles and indicators of psychological well-being, including anxiety, depression, and loneliness. Results identified indirect aggression (encompassing passive-aggressive behaviors such as hostile silence, nonverbal aggression, and subtle sabotage) as the strongest and most consistent predictor of

adverse mental health outcomes.

By comparison, a profile characterized by high collaboration and minimal indirect aggression, “Direct Conflict Managers”, was associated with significantly lower levels of anxiety, depression, and loneliness. Multifaceted profiles incorporating intense mixtures of styles, particularly those including indirect aggression, exhibited the poorest well-being indicators [9].

Specific dysfunctional combinations produced distinct effects: indirect aggression combined with accommodation increased anxiety, while indirect aggression paired with reduced collaboration predisposed individuals to depression. These patterns demonstrate that avoidance or indirect handling of conflict imposes a substantial emotional and relational burden, eroding resilience and elevating the risk of mood disorders [9].

In professional settings, conflicts involving patients, supervisors, or bidirectional work-family interference contribute to emotional exhaustion, which in turn mediates psychological distress. Higher perceived subjective social status serves as a protective factor.

Network analyses among mental health nurses revealed severe distress in 5.1%–6.4% of participants, with primary risk

factors including intense conflicts with patients and supervisors, patient mistreatment, and work-family conflict. Emotional exhaustion emerged as the strongest mediator of distress, while work-family conflict constituted the principal driver of exhaustion [16]. These findings underscore the necessity of organizational interventions that foster psychological safety and minimize chronic conflict in emotionally demanding professions.

Constructive conflict styles, particularly collaboration and principled compromise, safeguard relational integrity and alleviate emotional load. Prolonged avoidance or passive-aggressiveness, however, amplifies isolation, resentment, and susceptibility to secondary relational trauma. Incorporating training in emotional intelligence, emotion regulation, and forgiveness promotion into conflict management programs is therefore essential for preventing adverse mental health consequences, as Program on Negotiation at Harvard Law School [15].

Effective conflict management entails a transition from maladaptive patterns (avoidant or indirect-aggressive) toward direct, collaborative, and forgiveness-oriented approaches. Such shifts yield demonstrable benefits in reducing

anxiety, depression, loneliness, and emotional exhaustion, while simultaneously resolving acute conflicts and interrupting longer-term cycles of relational deterioration and psychological trauma [6].

3. THE PSYCHOLOGICAL IMPLICATIONS OF TRAUMA IN A CONFLICT CONTEXT

Interpersonal traumas, such as emotional abuse, domestic violence, sexual violence within relationships, persistent harassment, or repeated victimization, profoundly disrupt relational functioning and significantly elevate the risk of developing or exacerbating posttraumatic stress disorder (PTSD). A recent longitudinal systematic review concluded that the overall severity of PTSD symptoms constitutes a consistent and robust predictor of subsequent interpersonal revictimization.

While associations between specific symptom clusters (intrusion, avoidance, hyperarousal, negative alterations in cognition and mood) and revictimization risk remain inconsistent across studies, global PTSD severity reliably increases the likelihood of repeated exposure to interpersonal violence [12].

This feedback loop perpetuates progressive relational deterioration,

heightened social isolation, and intensification of posttraumatic symptomatology. Childhood interpersonal trauma, particularly emotional abuse, and neglect, frequently generates maladaptive relational schemas that manifest in adulthood as increased vulnerability to workplace conflict, social ostracism, and difficulties in detecting or responding adaptively to relational danger cues [20].

In intimate partnerships, PTSD symptomatology impairs constructive communication by fostering avoidance of emotional expression and generating patterns of unproductive or escalatory conflict that, in turn, maintain or worsen symptoms. The resulting consequences include elevated levels of anxiety and depression, diminished self-esteem, compromised relational satisfaction and functioning, and markedly increased risk of revictimization.

In contexts of chronic domestic violence or armed conflict, these effects may extend transgenerationally through the modeling and transmission of dysfunctional relational patterns. A central mechanism in this domain is interpersonal revictimization: the process whereby individuals with prior histories of interpersonal trauma are disproportionately exposed to

subsequent episodes of violence or abuse.

The aforementioned systematic review found no consistent evidence that individual symptom clusters (intrusion, avoidance, dissociation, hyperarousal) function as independent predictors; rather, cumulative PTSD severity emerges as the primary driver of repeated interpersonal trauma exposure [12].

Early interpersonal trauma, especially when cumulative (poly-victimization), is associated with elevated social anxiety in young adulthood, mediated by internalized shame and diminished emotional clarity [13]. Poly-victimization also amplifies symptoms of depression, anxiety, PTSD, guilt, shame, and despair to a greater degree than single-incident or non-interpersonal trauma [17].

In settings of prolonged armed conflict or pervasive interpersonal violence, the psychological burden is markedly exacerbated. Exposure to relational forms of trauma (domestic violence, sexual violence in intimate contexts, traumatic bereavement) is linked to higher prevalence and severity of PTSD, depression, and anxiety compared with non-relational war-related events [10].

Longitudinal data from conflict-affected populations indicate that sudden traumatic loss, forced

displacement, and chronic economic hardship sustain elevated symptoms of anxiety, depression, and PTSD over time, with disproportionately severe effects observed among women, ethnic minorities, and individuals with cumulative trauma exposure [2].

Interpersonal trauma frequently engenders moral injury, characterized by profound shame, guilt, despair, and erosion of trust in self and others, which further aggravates relational withdrawal and long-term psychosocial impairment [14]. High rates of comorbid mood and anxiety disorders (major depressive disorder, generalized anxiety disorder, social anxiety disorder) are consistently documented, alongside features of complex PTSD (CPTSD), including severe emotional dysregulation, disturbances in self-organization, identity fragmentation, and chronic relational difficulties.

Additional sequelae include impaired attachment processes, defensive or avoidant communication patterns, fear of intimacy, conflict escalation tendencies, and increased engagement in self-destructive behaviors (suicidal ideation, substance misuse, eating disorders). Transgenerational transmission of maladaptive schemas may occur through observational learning and disrupted parenting practices in

affected families.

In summary, trauma occurring within interpersonal and conflict contexts generates not only acute symptomatology but also enduring structural vulnerabilities that sustain suffering through repeated revictimization and progressive relational damage. The central position of overall PTSD severity within this cycle underscores the urgency of early, targeted interventions aimed at symptom reduction and restoration of capacity for safe, reciprocal relationships. Integrated treatment models that concurrently address individual posttraumatic symptoms and maladaptive relational dynamics are indispensable for interrupting these self-reinforcing patterns of interpersonal trauma.

4. INTERVENTION STRATEGIES BASED ON RECENT EVIDENCE

Effective management of interpersonal trauma, including experiences of domestic violence, relational abuse, and associated psychological burden, requires an integrated approach rather than a singular focus on posttraumatic stress disorder (PTSD) symptoms. Interventions should simultaneously target core posttraumatic symptoms

(e.g., intrusions, hypervigilance, avoidance), disrupted relational patterns, and mechanisms that perpetuate maladaptive cycles to prevent revictimization.

Evidence accumulated in recent years supports trauma-focused psychotherapies as the most efficacious interventions. These approaches directly address the underlying mechanisms of trauma, yield substantial reductions in symptomatology, and facilitate long-term relational recovery. Notably, therapeutic gains often become more pronounced and stable over extended follow-up periods.

For example, a study examining women who had experienced intimate partner violence demonstrated that trauma-focused cognitive-behavioral therapy (TF-CBT), delivered in either its standard form or with an additional component involving positive memory recall (CBT-M+), produced large reductions in PTSD symptoms ($\eta_p^2 = 0.42$), as well as moderate reductions in anxiety ($\eta_p^2 = 0.25$), depression ($\eta_p^2 = 0.21$), improvements in self-esteem ($\eta_p^2 = 0.33$), and enhanced general functioning ($\eta_p^2 = 0.28$).

These effects were maintained at 12-month follow-up. Furthermore, both variants significantly decreased the prevalence of subsequent psychological violence (from 90%

to 52.5%), physical violence (from 82.5% to 30%), and sexual violence (from 62.5% to 15%), indicating a meaningful interruption of the revictimization cycle [7].

In cases of complex or repeated trauma, the therapeutic alliance assumes central importance, providing a foundation of trust essential for narrative reconstruction and relational repair. Interpersonal and psychodynamic approaches yield symptom reductions comparable to those achieved through exposure-based methods, while demonstrating advantages in treatment retention. Integrating specific skill-building components, such as constructive conflict management, collaborative problem-solving, and processes related to forgiveness (distinct from reconciliation), further supports relational stabilization, and reduces the likelihood of future trauma exposure [1].

The revised APA Clinical Practice Guideline (2025) designates Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) as strongly recommended first-line interventions for adults with PTSD. These approaches demonstrate robust evidence for reducing core symptom clusters (intrusions, avoidance, hyperarousal, negative alterations in

cognition and mood), with durable effects observed at 6–12 months post-treatment.

The guideline emphasizes the importance of individual adaptation, patient preferences, comorbidity considerations, and cultural context, while prioritizing individual psychotherapy over pharmacotherapy as the primary modality [1].

For survivors of intimate partner violence (IPV), adapted forms of TF-CBT, including variants with positive memory components (CBT-M+), exhibit particularly favorable long-term outcomes in preventing revictimization. No substantial differences in efficacy have been observed between standard and enhanced versions, suggesting that core mechanisms (cognitive restructuring, emotion regulation, and self-protective skill development) drive the observed benefits [7].

In clinical settings, these trauma-focused interventions remain effective beyond tightly controlled trials, although treatment retention continues to present challenges, particularly among vulnerable populations. Recent observations indicate dropout rates in the range of 15–20% in naturalistic contexts [18].

Augmentation with modular components, such as Skills Training in Affective and Interpersonal

Regulation (STAIR) for emotional and relational regulation, or elements drawn from Acceptance and Commitment Therapy (ACT), appears to enhance initial engagement and long-term adherence, especially among individuals with complex comorbidity profiles or veterans [5].

For presentations consistent with complex PTSD (CPTSD) or those involving pronounced relational impairment, contemporary guidelines advocate a phased treatment model: (1) stabilization and safety planning (including emotional regulation and establishment of interpersonal safety), (2) trauma processing, and (3) relational reconstruction and reintegration. Meta-analytic evidence supports the efficacy of Interpersonal Psychotherapy (IPT) and psychodynamic approaches in this context. These modalities achieve PTSD symptom reduction comparable to exposure-based treatments while offering additional benefits for interpersonal functioning and lower attrition rates [11]. IPT specifically targets isolation and posttraumatic relational difficulties.

An additional low-intensity, scalable digital adjunct involves a brief imagery-competing task utilizing Tetris gameplay following memory reactivation. This intervention has demonstrated substantial reductions

in intrusive memories and overall PTSD symptomatology among healthcare professionals exposed to trauma, particularly during the COVID-19 pandemic [3]. Given its simplicity, minimal cost, and ease of dissemination, it represents a promising supplementary tool within broader trauma-informed care.

In summary, current evidence strongly favors trauma-focused therapies (CPT, PE, TF-CBT) as first-line interventions for interrupting symptom maintenance and revictimization cycles in interpersonal trauma. Combining these approaches with relational interventions (e.g., IPT, communication and conflict-resolution training) within a phased, personalized framework enhances both depth and durability of recovery. Successful implementation requires careful attention to individual presentation, retention strategies, and real-world contextual factors (clinical, occupational, and community settings) to meaningfully alter the long-term course of relationally derived trauma.

5. CONCLUSIONS

Interpersonal conflicts and psychological trauma exhibit a closely intertwined, bidirectional relationship. Contemporary empirical evidence clearly

demonstrates that maladaptively managed conflicts, characterized by avoidance, passive-aggressive patterns, unnecessary escalation, or explosive reactions, substantially elevate the risk of precipitating new traumatic experiences, perpetuating revictimization, and contributing to the chronicity of posttraumatic stress disorder (PTSD) symptoms.

Conversely, pre-existing trauma, particularly when originating from childhood interpersonal experiences or prior toxic relationships, markedly impairs the capacity for clear communication, adaptive emotional regulation, and collaborative problem-solving. This impairment reinforces repetitive maladaptive relational cycles, transmitting psychological distress across family, intimate, occupational, and community systems.

Individual-level treatment conducted in isolation proves insufficient to address these dynamics effectively. A comprehensive approach must extend beyond symptom-focused therapy to encompass the broader relational and contextual environment. This includes supporting families, couples, and workgroups in transitioning toward safer, more empathic, and collaborative interaction patterns characterized by genuine listening

and joint resolution rather than domination or withdrawal.

Implementation of such integrated strategies holds the potential to reduce the collective psychological burden associated with interpersonal trauma, thereby enhancing resilience at both individual and societal levels in the face of crises, conflicts, or adversity.

Promising directions for future research include the development and evaluation of hybrid interventions that explicitly combine structured conflict management training with trauma processing techniques. These approaches warrant particular attention in high-risk contexts such as armed conflict zones, forced migration settings, and other vulnerable communities. Although data on diverse and underrepresented populations remain limited, the theoretical and clinical rationale for such integrated models is compelling and merits rigorous investigation.

Ultimately, relationally derived traumas cannot be adequately resolved through individual psychotherapy alone. Sustainable recovery requires concurrent transformation of everyday relational practices. Absent such systemic change, entrenched patterns of dysfunction and distress are likely to persist.

AI DISCLOSURE

The authors confirm that Grok from X.AI tools were used in the preparation of this manuscript, to identify the latest current bibliographic references. All content is solely the product of original human intellectual effort and authorship.

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