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Ph.D. DISSERTATION

Gyulnaz Nasuf HALIL



THE REPUBLIC OF TÜRKİYE
ANKARA YILDIRIM BEYAZIT UNIVERSITY
THE GRADUATE SCHOOL OF SOCIAL SCIENCES

THE EFFICACY OF COGNITIVE-BEHAVIORAL THERAPY (CBT) AND ACCEPTANCE AND COMMITMENT THERAPY (ACT) IN MITIGATING THE EFFECTS OF EMOTIONAL ABUSE AMONG TURKISH WOMEN: AN EXPERIMENTAL DESIGN STUDY

Gyulnaz Nasuf HALIL

DEPARTMENT OF PSYCHOLOGY

Ankara, 2025

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Thesis Supervisor
Prof. Dr. Hüdayar CIHAN

Ankara, 2025

APPROVAL PAGE

The doctoral dissertation titled "The Efficacy of Cognitive-Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT) in Mitigating the Effects of Emotional Abuse among Turkish Women: An Experimental Design Study" prepared by Gyulnaz Nasuf Halil has been accepted as a doctoral thesis by majority vote by the jury listed below in the Department of Psychology, Institute of Social Sciences, Ankara Yıldırım Beyazit University.

Jury Member	Accept/Reject	Institution	Signature
Prof. Dr. Hüdayar CIHAN	Accept	Ankara Yıldırım Beyazıt University	
Asist. Prof. Dr. Özlem ERSAN	Accept	Ankara Yıldırım Beyazıt University	
Asist. Prof. Dr. Elif Emir ÖKSÜZ	Accept	Ankara Yıldırım Beyazıt University	
Prof. Dr. Hatice DEMİRBAŞ	Accept	Ankara Hacı Bayram Veli University	
Asist. Prof. Dr. Emel GENÇ	Accept	Bartın University	

Date of Thesis Defense: 04 / 08 / 2025

I hereby confirm that the candidate has fulfilled the necessary requirements for the dissertation to be accepted as a doctoral thesis in the Department of Psychology, Institute of Social Sciences, Ankara Yıldırım Beyazit University.

Assoc. Prof. Dr. Muhammet Enes KALA
Director of the Institute of Social Science

DECLARATION

I hereby declare that this thesis is my own original work and that I have not engaged in any unethical conduct that would violate patent or copyright laws during any stage of the thesis, from planning to writing. I affirm that all information in this thesis has been obtained in accordance with academic and ethical standards, and that all sources of information and interpretations used have been properly cited.

Date: (04 / 08/ 2025)

Signature:

Name:

DEDICATION

Dedicated to all women whose resilience
in the face of emotional abuse
inspires this work.

ACKNOWLEDGMENTS

Completing this dissertation has been one of the most challenging and transformative journeys of my life—a journey that I could not have navigated alone. I would like to begin by acknowledging the inner strength, resilience, and persistence that allowed me to continue even when the road felt overwhelming. I thank myself for showing up, again and again, with courage and determination.

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To everyone who has walked beside me during this journey—thank you from the bottom of my heart.

ÖZET

Türk Kadınlarında Duygusal İstismarın Etkilerini Azaltmada Bilişsel Davranışçı Terapi (BDT) ve Kabul ve Kararlılık Terapisi'nin (KKT) Etkililiği: Deneysel Tasarımlı Bir Araştırma

Bu çalışma, duygusal istismara maruz kalan Türk kadınlarının iyi oluşunu artırmak amacıyla Bilişsel Davranışçı Terapi (BDT) ve Kabul ve Kararlılık Terapisi'ne (KKT) dayalı bir müdahale programı geliştirmiş ve uygulamıştır. Müdahale; duygusal istismarı (uygulama ve maruz kalma boyutları) ve algılanan stresi azaltmayı, aynı zamanda duygu düzenleme ve psikolojik iyi oluşu artırmayı hedeflemiştir. Müdahale içeriğini, yapısını ve değerlendirme prosedürlerini iyileştirmek amacıyla bir pilot çalışma (N = 24) gerçekleştirilmiştir. Ana rastgele kontrollü çalışmada (N = 60) katılımcılar müdahale veya bekleme listesi kontrol grubuna atanmıştır. Dokuz haftalık program, BDT stratejilerini KKT yöntemleri ile birleştirmiştir. Standart ölçüm araçları—Bilişsel Duygu Düzenleme Ölçeği (CERQ), Çok Boyutlu Duygusal İstismar Ölçeği (MMEA), PERMA İyi Oluş Ölçeği ve Algılanan Stres Ölçeği (PSS)—ön test, son test ve iki aylık izleme aşamalarında uygulanmıştır. Müdahale grubunda, kontrol grubuna kıyasla uyumsal duygu düzenleme ve psikolojik iyi oluşta anlamlı düzeyde artış; algılanan stres ile duygusal istismar uygulama ve maruz kalma düzeylerinde ise anlamlı azalma gözlenmiştir. Bu etkilerin çoğu izleme aşamasında da korunmuştur. Sınırlılıklar arasında; küçük ve homojen (evli Türk kadınlarından oluşan) bir örneklem, öz-bildirim verilerine dayanma, kısa izleme süresi ve partner ya da klinisyen değerlendirmelerinin bulunmaması yer almaktadır. Klinik açıdan bulgular, yapılandırılmış, düşük maliyetli ve travma odaklı BDT–KKT programının, duygusal istismara maruz kalan kadınlarda duygusal iyileşme, psikolojik dayanıklılık ve ilişkisel sağlığı artırma potansiyelini ortaya koymaktadır. Bu yaklaşım, hem klinik hem de toplumsal ortamlarda uygulanabilir olup, önleme ve tedavi programlarına entegre edilme açısından umut vadetmektedir.

Anahtar Kelimeler: Bilişsel Davranışçı Terapi (BDT); Kabul ve Kararlılık Terapisi (KKT); Duygusal istismar; Türk kadınlar; Müdahale Programı;

ABSTRACT

The Efficacy off Cognitive-Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT) in Mitigating the Effects of Emotional Abuse Among Turkish Women: An Experimental Design Study

This study developed and implemented a Cognitive-Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT)-based intervention program to enhance the well-being of Turkish women exposed to emotional abuse.The intervention was designed to reduce emotional abuse (perpetration and victimization) and perceived stress while improving emotion regulation and psychological well-being. A pilot study (N = 24) was conducted to refine the program content, structure, and assessment procedures. The main randomized controlled trial (N = 60) assigned participants to either an intervention or waitlist control group. The nine-week program combined CBT strategies with ACT methods. Standardized measures—the Cognitive Emotion Regulation Questionnaire (CERQ), Multidimensional Measure of Emotional Abuse (MMEA), PERMA Well-Being Scale, and Perceived Stress Scale (PSS)—were administered at baseline, post-test, and two-month follow-up. The intervention group demonstrated statistically significant improvements in adaptive emotion regulation and psychological well-being, alongside reductions in perceived stress and both emotional abuse perpetration and victimization compared with the control group. Most effects were maintained at follow-up. Limitations include the use of a small, homogeneous sample of married Turkish women, reliance on self-report data, a short follow-up period, and the absence of partner or clinician-reported assessments. Clinically, the findings highlight the potential of a structured, low-cost, and trauma-informed CBT–ACT program to enhance emotional recovery, resilience, and relational health in women affected by emotional abuse. The approach is applicable in both clinical and community settings and holds promise for integration into prevention as well as treatment frameworks.

Keywords: Cognitive-Behavioral Therapy (CBT); Acceptance and Commitment Therapy (ACT); Emotional abuse; Turkish women; Intervention Program;

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1. INTRODUCTION

Intimate partner violence (IPV) is widely acknowledged as a serious violation of human rights and a major public and global health issue. It encompasses multiple forms of harm, including physical, sexual, emotional, psychological, and economic abuse. Among these, emotional abuse is particularly insidious due to its nonphysical nature and its reliance on strategies designed to inflict psychological harm. Such strategies include domination, isolation, humiliation, intimidation, and stalking. Despite the severity of its impact, emotional abuse remains less understood in both research and clinical practice, largely because of the limited body of literature focusing specifically on its unique characteristics and consequences. Studies have shown that many women perceive emotional abuse as more damaging than physical abuse. However, its subtle, often invisible presentation makes it difficult to detect, articulate, and address effectively, frequently going unnoticed or unacknowledged (Abusbaitan et al., 2025).

1.1.Emotional Abuse

Emotional abuse has been defined using a plethora of terms throughout the literature on intimate partner violence (IPV), including psychological abuse, verbal abuse, psychological aggression, and emotional or verbal maltreatment (Follingstad, 2007). Researchers in the IPV field may find it confusing when these terms are frequently used interchangeably, but this also suggests that clinicians remain uncertain about how to conceptualize and evaluate this form of abuse in intimate partner relationships (Peatee, 2018). Abusive behaviors can be categorized as controlling–managing, threatening–punishing, and underestimating–judging. Going through a partner's personal belongings, monitoring them in real or virtual environments, and removing them from their social environment are examples of control/management-oriented

emotional abuse. Behaviors such as threatening to leave or cause harm, cutting off financial income, and deliberately leaving the partner alone are examples of emotional abuse focused on threats and punishment. Similarly, setting rules for one's partner and making decisions on their behalf, not seeking their opinion on important matters, exploiting them socially, financially, materially, or physically, questioning their success and competence, and blaming or belittling their decisions represent emotional abuse centered on trivialization and judgment (Seçim, 2019). Jordan, Campbell, and Follingstad (2010) asserted that emotional abuse in romantic relationships can be conceptualized as behaviors that exceed a specific threshold on a continuum of psychologically aggressive or problematic relational acts. The use of verbal or nonverbal acts such as threats of harm, frequent criticism, humiliation, intimidation, manipulation, isolation, terrorizing, severe punishment, or threats to harm oneself or to abandon the partner, as well as expressions of jealousy, are characteristic of emotional IPV. Despite persistent definitional and methodological challenges, research has demonstrated the necessity of continuing to study psychological abuse in intimate relationships (Peatee, 2018).

1.2. Prevalence

Emotional abuse is frequently excluded from large-scale IPV research due to the absence of a universally accepted definition. For example, the WHO multi-country study conducted across 15 sites in 10 countries—including Brazil, Bangladesh, Ethiopia, and Japan—did not report a single global prevalence rate because of cultural variations in how emotional abuse is perceived. Instead, it documented the frequency of specific emotionally abusive behaviors (Garcia-Moreno et al., 2006). Similarly, other large-scale studies have omitted emotional abuse entirely for methodological reasons (Stern et al., 2019). These challenges emphasize the need

for culturally sensitive and standardized definitions to guide research and inform intervention strategies (Schumacher et al., 2001).

Despite these difficulties, available evidence shows that emotional abuse is among the most prevalent forms of IPV worldwide. The WHO multi-country survey reported that between 20% and 75% of intimate partners engaged in psychological abuse regularly (Tirado-Muñoz et al., 2014; Glaser, 2002). WHO (2020) estimates indicate regional prevalence rates for psychological/emotional abuse against women of 34% in the Americas, 31% in Europe, 43% in the Eastern Mediterranean, and 46% in Africa. In certain Eastern countries, rates can be extremely high up to 98%. For example, 80% of Jordanian women reported experiencing emotional abuse (Abujilban et al., 2021), while rates were 57.8% in Ethiopia (Fekadu et al., 2018) and 56.9% in Ecuador (Edeby & San Sebastián, 2021). Similar patterns have been documented in Zimbabwe and other Sub-Saharan African countries (Mukamana et al., 2020).

In Türkiye, national statistics indicate high prevalence rates as well. The Turkish Statistical Institute (TUIK) reported that in 2014, 43.9% of women had experienced psychological violence and 23.4% had experienced economic violence perpetrated by their husbands, with the rate of psychological abuse recorded at 40% in 2020 (Bozkurt et al., 2023). Hatunoğlu et al. (2014) found that 44% of Turkish women had been subjected to emotional abuse, with swearing identified as the most common behavior (37%), followed by humiliation and intimidation. Rates varied by education and age at marriage: 37% among women with at least a high school education versus 50% among women with no or incomplete primary education; 42% among women married after 18 versus 51% among those married before 18. Naçar et al. (2009) similarly reported verbal violence as the most common form (32.4%) and

noted that nearly half of the women surveyed considered violence against women to be justified.

International data also show high prevalence among adolescents and young adults. Wolfe et al. (2004) highlight that emotional abuse frequently occurs in dating relationships. The U.S. National Intimate Partner and Sexual Violence Survey (NISVS) found that 47.1% of women and 47.3% of men reported experiencing at least one psychologically aggressive behavior from a partner during their lifetime (Smith et al., 2017). Within that, 41% of women and 43% of men experienced coercive control, while 40% of women and 32% of men experienced expressive aggression. Carney and Barner (2012) reported similar lifetime exposure rates (40% of women and 32% of men). Other studies show that women tend to report higher perceptions of emotional abuse than men (Murty et al., 2003; Vinayak & Safariolyaei, 2017; Karanis, 2016).

Emotional abuse often occurs alongside other forms of IPV, particularly physical and sexual violence, and can persist even after these other forms have ceased (Aktas & Demirduzen, 2017). It is also commonly identified as a central feature underlying multiple types of abuse. Black et al. (2011) found that nearly half of Americans reported lifetime exposure to emotional abuse by a partner, most often involving coercive control (e.g., isolation, threats) and expressive aggression (e.g., name-calling). Follingstad and Rogers (2014) reported that 84% of participants had experienced at least one of 42 emotionally abusive behaviors in their most difficult cohabiting relationship, with “refusing to speak as punishment” being the most frequently reported (53%).

Cross-cultural comparisons of prevalence remain challenging because studies differ in sampling strategies, operational definitions, and whether they include threats and

psychological abuse in their IPV estimates (Stewart et al., 2016). Moreover, many victims do not recognize psychological abuse as "abuse" because it lacks visible injuries such as bruises or broken bones, leading to underreporting and legal inaction (Goldsmith & Freyd, 2005; Follingstad, 2009). In Follingstad and Rogers' (2014) study, while many participants reported experiencing multiple psychologically abusive behaviors, 31% still described their worst romantic partner as "not abusive."

Discrepancies also exist between professional and lay definitions of psychological abuse. Nonprofessionals focus on whether the victim experienced obvious harm, whereas professionals often assess severity based on frequency and duration of behaviors. This difference suggests that individuals' subjective perceptions of abuse, as well as their descriptions of their relationships, can shape both the recognition and the documented impact of emotional abuse on mental health (Follingstad et al., 2004; Follingstad & Dehart, 2000).

Although both men and women can be victims of emotional abuse, the consequences for physical and mental health are profound in all cases. Evidence suggests that nearly all victims of physical IPV also experience significant psychological abuse, yet emotional abuse has historically received less attention in research and policy discussions compared to physical and sexual violence (Langhinrichsen-Rohling et al., 2004; Berkel et al., 2005). One contributing factor, as noted by Jordan, Campbell, and Follingstad (2010), is the common practice of combining the effects of psychological and physical abuse, making it difficult to isolate and fully understand the specific impact of emotional abuse in intimate relationships.

1.3. Mental Health Consequences

A substantial body of research documents the profound negative effects of emotional abuse (EA) on mental and physical health. As a form of intimate partner violence that does not involve physical force, EA often causes damage that is equal to or even greater than that caused by physical abuse (Ersanli et al., 2013). Emotional abuse constitutes a form of psychological trauma, and—like other traumatic experiences—it can lead to post-traumatic stress disorder (PTSD) and other long-term psychological disturbances. PTSD is one of the most well-documented outcomes of trauma from IPV, including EA. Exposure to EA in romantic relationships undermines holistic health, affecting both psychological and physical functioning. Feelings of fear and increased dependency are closely linked to low self-esteem (Murphy & Hoover, 1999), and victims may avoid future relationships altogether due to the psychological scars left by abuse (Öngün & Uysal, 2018).

EA can also lead to intense feelings of loneliness and hopelessness, sometimes more pronounced than in cases of physical abuse (Loring, 1994). Victims often withdraw from social circles out of fear, shame, or coercion by their partners (Arabaci & Uygun, 2022). Research on dating violence shows that such isolation is often deliberately enforced by the abusive partner, gradually increasing the victim's loneliness (Açıkalın & Şahin, 2021). Cyberbullying and social media misuse can exacerbate these effects, particularly among adolescents, leading to exclusion and social withdrawal (Ünal & Küçük, 2022).

The psychological trauma caused by EA can also manifest as physical health problems. Van Houdenhove et al. (2001) found links between emotional abuse or neglect and conditions such as fibromyalgia and chronic fatigue syndrome. In Türkiye, EA within the family has been associated with somatization disorder (Özenli et al., 2009), and

individuals with medically unexplained physiological symptoms frequently report high rates of EA (66%) (Anuk & Bahadir, 2017).

EA is not only a mechanism of psychological harm but also a powerful tool of control in abusive relationships—sometimes a stronger predictor of divorce or separation than the frequency of physical assaults (Jacobson et al., 1996). Symptoms may include heightened arousal, avoidance behaviors, emotional numbing, intrusive recollections, and a persistent sense of threat (Echeburúa et al., 2014). Other mental health consequences include anxiety, depression, low self-esteem, somatic complaints, and impaired functioning in occupational, social, and intimate roles.

Studies in Türkiye reveal that women exposed to IPV often display passive, avoidant, and emotion-oriented coping strategies. Although many believe violence is unjustifiable and that perpetrators should be punished, common responses include remaining silent, concealing the abuse due to shame, self-blame, fear of social condemnation, and not pursuing legal action—particularly among those experiencing physical IPV (Gumus et al., 2020).

International research confirms that women who have experienced only psychological abuse are more than twice as likely to develop psychological distress, especially depression, compared to those who have not been abused (Estefan et al., 2016). These effects can persist for years after the abuse has ended. Victims may experience chronic health problems, reduced energy, diminished self-worth, and weakened social support networks, often leading to a loss of life purpose (Diez et al., 2009).

Resilience—ability and recovering—is a critical protective factor for IPV survivors. However, resilience can be undermined by victim-blaming attitudes, inadequate law enforcement response, and insufficient social and therapeutic support (Picó-Alfonso et al., 2008). Survivors who do cultivate resilience often do so through self-acceptance, reframing perspectives, and finding meaning in life despite adversity (Noviyanti et al., 2018). Core resilience components include emotion regulation, self-control, self-efficacy, empathy, and the capacity to seek help (Reivich & Shatté, 2002). Deficits in these areas can be addressed through targeted interventions that help survivors reframe beliefs, manage stress responses, and replace counterproductive thoughts with adaptive ones (Mulyani et al., 2020).

Two central dimensions of resilience are recovery—the ability to regain psychological balance after trauma—and sustainability—maintaining that balance over time through purposeful emotional engagement (Zautra, Hall, & Murray, 2010). While adult resilience research is more limited than childhood resilience studies, existing evidence shows that factors such as education, age, and ethnicity play important roles (Bonanno et al., 2007; Ryan, 2009).

Depression is one of the most consistently reported mental health outcomes of EA. Although PTSD is strongly associated with IPV, the link between EA and depression is particularly well established (Follingstad, 2009). Women subjected to EA by their partners report higher rates of depression and anxiety than non-abused women (Heise & Garcia, 2002; Dutton, 2006). Depression risk increases as psychological aggression intensifies (Jordan et al., 2010), and it is often accompanied by suicidality, especially when abuse is combined with physical violence (Tang, 1997). EA is also linked to somatic symptoms and

chronic pain, with studies showing significant associations between psychological IPV and reduced physical functioning (Coker et al., 2000; Hazen et al., 2008).

In summary, emotional abuse is both a form of psychological trauma and a pervasive control strategy that can trigger PTSD, depression, anxiety, and a range of physical health issues. Its invisible nature often delays recognition and intervention, but its long-term consequences for survivors' mental health, physical wellbeing, and social functioning are profound.

1.4. Theoretical Background

Cognitive-behavioral strategies are widely recognized as empirically supported interventions with high rates of positive outcomes in the management of clinical problems, particularly post-traumatic stress disorder (PTSD), in women exposed to intimate partner violence (IPV) (Dutton, 1992). Various treatment approaches have been shown to improve emotional functioning in IPV survivors, with CBT modalities offering the strongest empirical support for reducing the negative symptomatic effects of IPV (Eckhardt et al., 2013). Cognitive approaches can be used to challenge negative assumptions about the abuse, reassign blame to the perpetrator, increase awareness of feasible options within available resources, and manage dissociation (Resick et al., 2012). CBT emphasizes structured cognitive techniques, such as rehearsal exercises and cognitive restructuring, to help manage emotions and reduce maladaptive behaviors. The theoretical foundation of CBT holds that dysfunctional beliefs and automatic thoughts contribute directly to harmful behaviors and poor outcomes (Eckhardt et al., 2013).

Because of the complexity and recurrence of trauma among IPV survivors, their treatment needs are unique. There is growing evidence that mindfulness-based therapies may reduce trauma-related symptoms (Pitt et al., 2020). IPV survivors often face additional psychosocial stressors, including ongoing contact with the perpetrator (e.g., through shared parenting), economic hardship, lack of social support, and parenting-related pressures (Beck et al., 2014). Accessing conventional trauma-focused therapies can be both emotionally and practically challenging, particularly when safety concerns persist or when re-traumatization risks are present (Warshaw et al., 2013). Mindfulness-based therapies, which do not require trauma exposure work, may therefore be more acceptable to some survivors. Although the existing evidence base is modest due to underpowered studies and methodological limitations, a comprehensive review by Banks et al. (2015) found that mindfulness-oriented interventions produced reductions in PTSD symptoms among women with IPV and childhood maltreatment histories.

Acceptance and Commitment Therapy (ACT) incorporates mindfulness and acceptance strategies alongside values-based behavior change (Luoma et al., 2007). ACT teaches mindfulness skills to help individuals reduce avoidance and engage with distressing internal experiences—such as intrusive memories, rumination, guilt, or anger—without judgment (Walser & Westrup, 2007). One of ACT's central goals is to increase psychological flexibility, which is developed through acceptance, mindfulness, committed action, and behavior change strategies. Acceptance is defined as actively and nonjudgmentally embracing present experiences, instead of mere mere tolerance. Hayes (2004) describes acceptance as "undefended exposure" to thoughts, feelings, and bodily sensations as they naturally occur.

Like other mindfulness-based approaches within the CBT tradition, ACT emphasizes conscious awareness of thoughts as mental events rather than facts.

Empirical evidence supports ACT's effectiveness in trauma contexts. Amir et al. (2019) found that ACT increased positive cognitive regulation, resilience, and self-control while reducing negative cognitive regulation in divorced women. Mahmoudpour et al. (2021) demonstrated reduced loneliness and improved emotional regulation among divorced women in Iran. Nasution and Yusuf (2019) reported decreases in emotion regulation difficulties following ACT interventions, and Baberi et al. (2022) observed reductions in domestic violence and improvements in life attitudes in women experiencing emotional divorce. Comparative research by Valizadeh and Ahmadi (2022) indicated that both CBT and ACT significantly improved resilience and quality of life in women victims of domestic violence.

Although ACT research in Türkiye remains limited, initial findings are promising. Bal et al. (2015) reported successful smoking cessation in a case study using ACT. Other Turkish studies on mindfulness—one of ACT's six core processes—have explored its associations with humor styles (Özyesil et al., 2013), decision-making (Deniz et al., 2015), and reductions in depression and stress following mindfulness-based training (Demir, 2014).

1.5. Rationale for Integrating CBT and ACT: Comparison with Prior Interventions

Previous interventions for women experiencing intimate partner violence (IPV), particularly in the Turkish context, have often been limited to either psychoeducational programs or the use of a single therapeutic model such as Cognitive Behavioral Therapy (CBT). While these approaches have yielded some benefits—particularly in raising awareness and teaching coping skills—they frequently fail to produce lasting behavioral and emotional

change. Psychoeducational models tend to focus on providing information about abuse and rights. However, they may not equip participants with sufficient skills to manage intrusive thoughts, regulate intense emotions, or sustain adaptive behaviors over time. Similarly, CBT-only programs, while effective in restructuring maladaptive beliefs, may struggle to address the experiential avoidance and persistent distress that can remain even after cognitive change occurs.

The integration of CBT and Acceptance and Commitment Therapy (ACT) in the present study was designed to address these limitations by targeting both maladaptive cognitive content and the processes by which survivors engage with internal experiences. This dual focus not only supports symptom reduction but also fosters long-term resilience, values-based living, and greater psychological flexibility—outcomes that are critical for sustaining recovery in the face of complex, ongoing challenges often associated with emotional abuse. The decision to integrate CBT and ACT was informed by both theoretical considerations and empirical evidence on the recovery needs of women experiencing emotional abuse, recognizing that such abuse profoundly impacts cognitive, emotional, and behavioral functioning. Survivors often present with maladaptive thought patterns, diminished self-worth, heightened stress reactivity, and entrenched avoidance strategies. Effective intervention must address not only the content of dysfunctional beliefs but also the processes by which individuals relate to their internal experiences.

CBT was selected as a core component due to its extensive empirical validation in treating trauma-related conditions, including post-traumatic stress disorder (PTSD), depression, anxiety, and maladaptive cognitions among IPV survivors (Eckhardt et al., 2013; Resick et al., 2012). As a structured, skills-based approach, CBT offers survivors a systematic

framework for identifying and challenging distorted cognitions, reassigning responsibility for the abuse to the perpetrator, and dismantling patterns of self-blame and self-criticism. Such cognitive restructuring is crucial for women who have internalized the negative and demeaning messages from their abusive partners, often leading to a chronic erosion of self-esteem and self-efficacy. Additionally, CBT equips participants with problem-solving skills, behavioral activation strategies, and coping techniques that promote adaptive functioning and facilitate reintegration into supportive social networks.

However, while CBT excels at targeting the content of maladaptive thoughts, it does not always sufficiently address the context in which these thoughts occur or the tendency of survivors to engage in experiential avoidance. Many women affected by emotional abuse struggle with suppressing painful memories, avoiding triggering situations, and emotionally disengaging from their environment as a self-protective strategy. Over time, these avoidance patterns can generalize, reducing engagement with valued life activities and perpetuating isolation. This is where ACT serves as a complementary and equally vital therapeutic approach.

ACT, grounded in contextual behavioral science, focuses on enhancing psychological flexibility—the capacity to remain open and present to one's internal experiences while taking action guided by personal values (Hayes, 2004; Luoma et al., 2007). By teaching mindfulness skills and fostering acceptance of difficult emotions, ACT enables survivors to relate to distressing thoughts and feelings without judgment or resistance. This is particularly relevant in cases of emotional abuse, where intrusive memories, rumination, and self-doubt can dominate daily life. ACT interventions encourage survivors to observe these experiences from a compassionate detachment stance, reducing their power to dictate behavior. The therapy also

emphasizes values clarification and committed action, helping women to re-engage with meaningful goals and rebuild their lives even in the presence of residual distress.

The integration of CBT and ACT within a single intervention creates a dual-action therapeutic framework that addresses the multi-layered challenges faced by emotional abuse survivors. CBT directly modifies maladaptive cognitive content through evidence-based restructuring techniques, while ACT transforms the individual's relationship to that content by cultivating mindful acceptance and value-driven action. This synergistic combination allows the intervention to target multiple mechanisms of change: cognitive distortions, experiential avoidance, emotion dysregulation, and behavioral disengagement. As such, the program can appeal to participants with diverse coping styles—those who benefit from structured problem-solving as well and those who require strategies for tolerating and accepting unchangeable aspects of their experiences.

Empirical evidence further supports this integration. Psychological IPV has been shown to harm women's health as much as, and sometimes more than, physical or sexual IPV, functioning as a pervasive component in many abusive relationships (Carney & Barner, 2012). CBT-based interventions have demonstrated promising reductions in psychological IPV and its sequelae, equipping participants with cognitive coping tools, thought-stopping strategies, motivational interviewing techniques, and structured problem-solving (Tirado-Muñoz et al., 2014). However, barriers such as persistent post-traumatic symptoms, ongoing safety concerns, and a sense of helplessness often prevent survivors from fully accessing and benefiting from traditional cognitive interventions (Perez & Johnson, 2008). ACT's emphasis on psychological flexibility directly addresses these barriers, offering survivors a way to function effectively in their daily lives even when distress or environmental risks cannot be eliminated.

The combined use of CBT and ACT in the present study reflects a deliberate, evidence-informed choice aimed to produce comprehensive and sustainable outcomes. By jointly targeting the what (cognitive content) and the how (cognitive and emotional processes), the intervention provides a multifaceted skill set that empowers women to both reduce the impact of maladaptive beliefs and increase their ability to live meaningfully despite adversity. This integration is expected to maximize participant engagement, promote resilience, and enhance the overall effectiveness of the program in supporting recovery from emotional abuse.

1.6. Research Background

An examination of the literature in Türkiye reveals that most research focuses on domestic violence and violence against women, with relatively few studies investigating violence within romantic relationships. Even more limited are studies specifically examining emotional abuse in these contexts.

In the national field study Causes and Consequences of Domestic Violence, conducted by the Prime Ministry General Directorate of Family and Social Research in 1995, findings indicated that 34% of individuals reported exposure to physical violence in the family, while 53% reported exposure to verbal violence. A subsequent 1997 study by the same institution found that 12.3% of women reported frequent verbal insults from their husbands, and the overall rate of being insulted was 50% higher among women than men.

According to the Domestic Violence Against Women in Türkiye report published by the Ministry of Family and Social Policies (MoFSP) in 2014, 44% of women reported having experienced emotional abuse at some point in their lives. Interestingly, while participants identified male unemployment as a factor contributing to violence, the study

found no statistically significant relationship between men's employment status and their level of violence, contradicting a commonly held belief.

Çay (2006), in a study with 200 adult women, found that 75% reported experiencing emotional abuse. Participants described behaviors such as public humiliation, insults, derogatory labels about sexuality, dismissing their thoughts as worthless, and being yelled at as forms of emotional abuse. Similarly, Ayrancı et al. (2002) reported that in a sample of pregnant women, 99.1% had experienced verbal or psychological violence, with shouting, criticism, and scolding identified as the most frequent behaviors. In another study, Güler et al. (2005) found that among 162 women in Sivas, 47.4% reported exposure to verbal violence and 21.4% to emotional violence. The most frequently cited causes of violence in this study were financial difficulties, communication problems, alcohol or substance use, jealousy, and lack of affection.

Research among university students has revealed similar trends. A study at Hacettepe University (Sünetçi et al., 2016) found that approximately 14% of participants had experienced violence from their partner, and one in ten reported perpetrating violence against their partner. Behaviors such as restricting a partner's actions, exerting control and pressure, ignoring them, making decisions on their behalf, and interfering in personal matters (e.g., clothing, friendships) were identified as emotional abuse, yet often not recognized as violence by participants. Likewise, Fidan and Yeşil (2018), in a study of 60 Sakarya University students, found that all female participants had experienced emotional violence but tended to normalize and justify it, attributing it to their partner's character, social environment, or their own actions. Notably, only 5 women and 10 men ended their relationships due to violence, while many continued their relationships despite the abuse.

These findings illustrate that emotional abuse does not necessarily lead to relationship dissolution and may be sustained over time.

International research echoes these concerns. Liu et al. (2009) conducted a 30-month longitudinal study with 165 adults, assessing life events and emotional abuse levels every six weeks. They found that emotional abuse by romantic partners or figures of authority significantly predicted the onset of hopelessness and depression. Similarly, Ohnishi, Nakao, Shibayama, Matsuyama, Oishi, and Miyahara (2011), in a study with 274 students, identified controlling behaviors, verbal harassment, and coercive sexual acts as the most common forms of partner abuse. Emotional abuse was the most frequently reported category, with specific behaviors including unauthorized phone checks and interrogating a partner about their whereabouts and companions. Strikingly, all participants reported having engaged in abusive behavior at least once in their romantic relationships, and all reported having been subjected to abuse by their partner.

1.7. Importance of Research

Findings from both empirical studies and real-life observations indicate that romantic relationships, as a form of close interpersonal connection, can enhance individuals' well-being and play a significant role in fostering happiness. However, as in all relationships, conflicts and difficulties inevitably arise. One of the most prevalent and damaging issues—both to the relationship itself and to the individuals within it—is the presence of violence and abuse between partners. In Türkiye, as in many other societies, emotional abuse in romantic relationships is often neither recognized nor acknowledged as a form of violence by those who perpetrate it or experience it. Instead, it is frequently normalized. This normalization perpetuates abusive patterns, enables the continuation of

unhealthy relationships, and contributes to negative psychological consequences for those involved. Therefore, identifying and recognizing emotional abuse behaviors, as well as conducting research on their prevalence and consequences, are essential steps toward preventing this problem and addressing it as a public health concern.

A review of the literature reveals that, although numerous studies have been conducted on abuse in general, research on emotional abuse—particularly in Türkiye—remains insufficient. Domestic research has largely focused on childhood abuse and abuse occurring within the family context. In contrast, the number of studies specifically addressing emotional abuse in romantic relationships is limited. Emotional abuse, while common, is often difficult to detect; even when recognized, individuals may find it challenging to leave such relationships and may remain despite the harm. Expanding public and professional awareness of emotional abuse, as well as informing survivors, is likely to contribute to prevention and early intervention. Furthermore, understanding the factors that influence individuals' decisions to remain in abusive relationships may provide valuable insights for more accurate assessment of relationship health and dynamics.

Research on emotional violence and its effects is particularly important when such behaviors are widespread, reciprocal, and serve as a precursor to other forms of violence (Murphy & O'Leary, 1989). Similar to findings in the international literature, emotional abuse in Türkiye has been shown to have consequences as severe as those of physical abuse. The decision to leave, remain in, or return to an abusive relationship, and even to leave the abuser's social environment, are complex processes requiring informed and intentional decision-making (Dutton, 1992). Despite the high prevalence of domestic

violence, there remains a shortage of empirical evidence on the effectiveness of interventions for women who have experienced such abuse (Abel, 2000; Macy et al., 2013).

It is therefore crucial to assess both the frequency and severity of psychologically abusive behaviors in romantic relationships when evaluating their potential impact on mental health. While prior research has established associations between psychological abuse by a romantic partner and specific mental health outcomes, significant gaps remain. In particular, little is known about the mental health effects in populations exposed solely to psychological abuse—without concurrent physical or sexual violence—or how these effects may differ from those experienced by individuals subjected to multiple forms of abuse in intimate relationships (Eckhardt et al., 2013).

1.8. Aims of the Study

To date, no direct intervention for women exposed to emotional abuse in intimate relationships has been developed in Türkiye. The present intervention aims to increase participants' awareness of emotional abuse, foster more constructive communication, promote empathy, enhance anger regulation, and encourage rational thinking. Emotional abuse can occur in isolation or in combination with physical and sexual abuse. Despite being the most common form of abuse, it remains less clearly regulated by law compared to other forms. In this context, the study is significant in drawing the attention of policymakers to the seriousness of emotional abuse and in disseminating educational content that addresses it.

CBT was chosen for its strong evidence base in restructuring maladaptive thoughts and reducing PTSD and depression, while ACT was selected for its focus on psychological

flexibility, acceptance, and values-based living—key skills for survivors of abuse who face ongoing emotional challenges. For this purpose, the following hypotheses will be tested:

Hypothesis 1: There will be a significant difference in perceived stress levels between women who undergo the CBT- and ACT-based intervention and those in the control group.

Hypothesis 2: There will be a significant difference in psychological well-being between women who participate in the intervention and those in the control group.

Hypothesis 3: There will be a significant difference in emotion regulation between women who complete the intervention and those in the control group.

Hypothesis 4: There will be a significant difference in emotional abuse scores between women who receive the intervention and those in the control group.

2. PILOT STUDY

2.1.Participants

A total of 24 women aged between 25-65 participated in the study. Participants were assigned to experimental (N=12) and control group (N=12). The demographic information was obtained through administration of demographic form which included age group, gender, current relationship, status, duration of the relationship, sexual orientation, education level, employment status, number of children, the age of partner, the education of partner, the employment of partner, the question whether they live together or not.

There were 9 participants (34.6%) in the first age group 25-34, 10 participants (38.5%) in the second age group 35-44, 6 participants in the third age group 45-54, and 1 participant in the last age group 65 and more. The relationship status of the participants were married (24, 100%).

Most of the women were married 10 years and more (21, 80.8%), there were 4 women married between 5-10 years and one married between 2-5 years. All of the women were with heterosexual orientation. When it comes to education level, 7 participants were with bachelor's degree, followed by 9 participants were high school graduates, the number for secondary and other (which was elementary school) was equal 4 for each group, and lastly there were 2 participants with vocational high school and master's degree education.

Employment status distribution results suggested that 18 participants were housewives, followed by 5 participants who were employed full time, 2 students and 1 retired participant. While 9 of the participants have 2 children, the number for 1 and 3 children group was 8 each, and 1 participant did not have a child.

The partner's ages were distributed between 30 and 60 years old. Most of the partners were high school graduates (16, 61.5 %), followed by primary school graduates (5, 19.2%), 2 participants with bachelor's degree, 1 participant with master's degree and 1 drop out from high school. The number employment status of the partner for full time job was 18 (69.2 %), 3 (11.5%) individuals were retired, 4 individuals were unemployed (15.3%), and 1 (3.8%) were not consistent.

24 women indicated that they are living with their partners except two who chose the second option which was living separately.

2.2. Measures

2.2.1. Informed Consent Form

Informed consent form will be provided in order to outline the nature of the study its purpose procedures potential risks benefits and any rights participants might have.

2.2.2. Demographic form

The demographic form will involve question related to age group, gender, current relationship, status, duration of the relationship, sexual orientation, education level, employment status, number of children, the age of partner, the education of partner, the employment of partner, the question whether they live together or not.

2.2.3. The Brief Symptom Inventory (BSI),

The scale was developed by Derogatis in 1975, represents an important standardized screening instrument that enables one to quantitatively assess psychological distress and psychiatric disorders. It is a 53- self-report that measures nine dimensions that can be combined to represent three global indices: somatization, obsession–compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety and psychoticism. The internal consistency coefficients for the questionnaire's initial administration varied from 0.71 to 0.85 (Adawi et al., 2019).

The short symptom inventory was adapted into Turkish by Şahin and Durak (1994). Cronbach Alpha internal consistency coefficients obtained from three separate studies of the scale are 0.96 and 0.95 and the coefficients obtained for the subscales vary between 0.55 and 0.86.

2.2.4. Multidimensional Measure of Emotional Abuse (MMEA)

The Multidimensional Measure of Emotional Abuse (MMEA) was developed by Murphy and Hoover in 1999 to assess emotional abuse in intimate partner relationships. The scale consists of 56 items that evaluate various forms of emotional violence through a Likert-type format. Participants are asked to indicate how frequently certain experiences occurred in the past six months, with response options ranging from 0 (never happened) to 6 (more than 20 times). If the experience did not occur in the last six months but has happened before, the response "7" is selected. The scale captures both perpetration (the actions of the abusive partner) and victimization (the experiences of the abused partner).

The Turkish adaptation of the MMEA, conducted by Demirtaş et al. (2018), demonstrated strong psychometric properties. The perpetration subscale showed a Cronbach's alpha of 0.89, and the victimization subscale had a Cronbach's alpha of 0.90, indicating excellent internal consistency. The scale is an effective tool for measuring emotional abuse across various forms, including control, humiliation, hostile withdrawal, and threats, within intimate relationships.

In the current study, the internal consistency of the Multidimensional Measure of Emotional Abuse (MMEA) was assessed using Cronbach’s alpha. The analysis was conducted on the pre-test data collected from all participants (N = 24). The scale, which consists of 56 items, demonstrated excellent internal consistency, with a Cronbach’s alpha coefficient of .90. This result indicates that the scale items are highly interrelated and reliably measure the construct of emotional abuse within the study sample. The internal consistency of the Multidimensional Measure of Emotional Abuse (MMEA) subscales was evaluated using Cronbach’s alpha. The analysis yielded a Cronbach's alpha coefficient of

.77 for the 8-item subscale, indicating an acceptable level of internal reliability. This suggests that the items within the subscale are sufficiently interrelated and consistently measure the construct of emotional abuse.

2.2.5. PERMA Measurement Tool

The PERMA Measurement Tool is a 23-item self-report scale developed by Butler and Kern (2015, 2016) to assess the five pillars of well-being outlined in Seligman's PERMA model: Positive Emotions, Engagement, Relationships, Meaning, and Accomplishment.

The scale uses a five-point Likert-type scale, and responses are averaged for each subscale. The internal consistency for the overall scale was found to be $\alpha = 0.94$, with a test-retest stability of 0.78. In the Turkish context, the internal consistency reliability coefficient was 0.91, with subscale reliability coefficients ranging between 0.61 and 0.81. The test-retest correlation coefficient for the entire scale was 0.83, and for subscales, it ranged from 0.61 to 0.85. These findings demonstrate the scale's strong reliability and validity for assessing well-being in both general and clinical populations (Demirci et al., 2017).

The internal consistency of the PERMA Well-being Scale was assessed using Cronbach's alpha. The analysis was conducted on the pre-test responses of all participants ($N = 24$). The 23-item scale demonstrated high internal consistency, with a Cronbach's alpha coefficient of .898, indicating that the items reliably measure psychological well-being dimensions within the sample. The internal consistency of the PERMA subscales was assessed using Cronbach's alpha. The analysis revealed a Cronbach's alpha coefficient

of .70 for the 8-item subscale, indicating an acceptable level of reliability for research purposes.

2.2.6. Cognitive Emotion Regulation Questionnaire (CERQ)

The Cognitive Emotion Regulation Questionnaire (CERQ) is a 36-item scale developed by Garnefski et al. (2001), is designed to assess cognitive emotion regulation strategies used in response to negative life events. The scale measures nine different strategies (self-blame, acceptance, rumination, positive refocusing, refocusing, positive reappraisal, catastrophizing, blaming others, putting into perspective) that people use to cope with emotions following distressing situations. These strategies are categorized into adaptive and maladaptive strategies, reflecting how individuals cognitively manage their emotional responses:

The scale uses a five-point Likert scale to assess the frequency with which each strategy is employed, with scores ranging from 1 (almost never) to 5 (almost always). Each subscale is computed by summing the individual item scores, with scores for each strategy ranging from 4 to 20.

In the Turkish version of the Cognitive Emotion Regulation Questionnaire (CERQ), developed by Tuna and Bozo (2012), the psychometric properties were thoroughly examined. The internal consistency reliability of the subscales ranged from 0.72 for the self-blame subscale to 0.83 for the catastrophizing subscale, indicating good internal consistency across the measure. Additionally, the test-retest reliability of the subscales was found to range between 0.50 for blaming others and 0.70 for self-blame, suggesting stable results over time. These findings affirm the reliability and validity of the Turkish version

of the CERQ, making it an effective tool for assessing cognitive emotion regulation strategies.

The internal consistency of the Cognitive Emotion Regulation Questionnaire (CERQ) was evaluated using Cronbach's alpha. The analysis was based on pre-test data from all participants (N = 24). The 36-item version of the scale showed acceptable internal consistency, with a Cronbach's alpha coefficient of .793, suggesting that the CERQ reliably measures cognitive emotion regulation strategies in this sample. The internal consistency of the Cognitive Emotion Regulation Questionnaire (CERQ) subscales was evaluated using Cronbach's alpha. The analysis resulted in a Cronbach's alpha of .52 for the 9-item scale, indicating a questionable level of reliability. This suggests that the subscale may have limited internal consistency and should be interpreted with caution.

2.2.7. Perceived Stress Scale (PSS)

The scale was developed by Cohen et al. (1983) to measure the extent to which a person perceives his or her life as unpredictable, uncontrollable, or overloaded. It is a 14-item self-rating scale where individuals are asked to rate how often they have experienced certain emotions or thoughts in the last month, between 0 (not at all) and 5 (very often). The reported internal consistency of the scale indicated by Cronbach's alpha ranged from.71 to .91, while the test-retest reliability has been generally observed at r > .70 among different populationsç

The adaptation of the Perceived Stress Scale into Turkish was carried out by Yerlikaya and İnanç. In the study, the internal consistency coefficients were 0.84, 0.82 and 0.66 and test-retest reliability coefficients were calculated as 0.87, 0.88 and 0.72, respectively (Eskin et al., 2013).

The 14-item version of the Perceived Stress Scale (PSS) showed very low internal consistency in the present study (Cronbach's $\alpha = .24$; $N = 24$). This result suggests that the scale did not function reliably within the sample, possibly due to uncorrected reverse-coded items or other measurement issues. Further item-level review and proper recoding are recommended before interpreting the scale scores.

2.3.Procedure

Ethical approval for the study was obtained from Ankara Yıldırım Beyazıt University Ethics Committee (Decision No: 17-01-2024/01-282). Participants were recruited from a group connected to a local community center in Sincan, Ankara. All potential participants were screened according to the study's inclusion and exclusion criteria. The inclusion criteria required participants to be: (1) women, (2) Turkish citizens, and (3) at least 18 years of age. The exclusion criteria involved screening for serious psychopathology using the Brief Symptom Inventory (BSI) and excluding individuals who self-identified as having an existing mental health condition. In line with standard recommendations for community-based samples, a BSI Global Severity Index (GSI) score above 1.00 was considered an indicator of severe psychological distress and used as the cut-off point for exclusion.

A total of 27 women expressed interest and were provided with an Informed Consent Form and Demographic Information Form, followed by administration of the BSI. After the screening process, three participants withdrew due to scheduling conflicts, leaving a final sample of 24 participants. All participants scored below the exclusion threshold on the BSI and were therefore eligible to continue. They were randomly assigned to either the experimental group ($n = 12$) or the control group ($n = 12$).

The experimental group attended a structured, nine-week CBT- and ACT-based intervention program designed specifically for this study and conducted at the community center. Sessions took place once a week, lasting 90 minutes. The weekly content followed a standardized format (see Table 1).

In the first week, prior to the start of the intervention, all experimental group participants completed a battery of standardized self-report instruments under pre-test conditions:

- Multidimensional Measure of Emotional Abuse (MMEA) – to assess the frequency and nature of emotionally abusive behaviors experienced in intimate relationships, capturing both perpetration and victimization.
- PERMA Measurement Tool – to evaluate psychological wellbeing across five domains (Positive Emotion, Engagement, Relationships, Meaning, and Accomplishment).
- Cognitive Emotion Regulation Questionnaire (CERQ) – to measure cognitive strategies used in response to stressful life events, distinguishing between adaptive and maladaptive regulation patterns.
- Perceived Stress Scale (PSS) – to assess the degree to which participants appraise their lives as stressful over the past month.

All measures were administered in a quiet, private setting at the community center to ensure confidentiality and minimize distractions. The facilitator provided standardized instructions, clarified questions without leading responses, and ensured all questionnaires were completed independently.

The same measures were administered at two additional time points:

1. Immediately after the nine-week program (post-test) – to assess short-term changes in emotional abuse scores, wellbeing, emotion regulation, and perceived stress.
2. Three weeks after post-test (follow-up) – to evaluate the stability and retention of changes, providing insight into short-term sustainability beyond the active intervention phase.

The control group was placed on a waitlist and received no intervention during the study period. This waitlist control design was selected for ethical reasons—ensuring that all participants would eventually have access to the program—and for methodological purposes, allowing comparison between those receiving the intervention and those not receiving it within the same timeframe to isolate intervention effects.

Attendance and engagement in the intervention group were exceptionally high; no participant missed a session. Participants were consistently motivated, open to new experiences, and willing to share personal reflections. A culturally significant practice emerged organically during the sessions: each week, participants brought homemade foods—such as biscuits, pastries, and other traditional Turkish treats—to share with the group. This act reflected Turkish values of hospitality, generosity, and communal care, fostering a warm and supportive group atmosphere. It also served as a social bonding activity, helping to reduce initial barriers between participants and enhancing trust, which enriched the therapeutic process.

Intervention Program

The intervention consisted of nine structured weekly sessions, each lasting between 90 minutes, delivered in a group format at the community center. The program combined cognitive-behavioral therapy (CBT) and acceptance and commitment therapy (ACT) principles to address emotional abuse awareness, coping skills, emotional regulation, and relational health.

The session began with an introduction to the weekly plan and an opportunity for participants to express their personal goals for the study. Participants introduced themselves and shared the experiences that motivated their participation. Group rules and norms were established collaboratively, emphasizing respect for opinions, feelings, and personal space, as well as confidentiality. The group agreed on the importance of avoiding criticism, attentive listening without interruption, and using respectful language to maintain a supportive atmosphere. An ice-breaker activity, *Ten Things in Common*, was conducted to promote comfort, cooperation, and rapport. Small groups identified shared interests or experiences, followed by a group discussion to reflect on the activity.

The second session began with an open discussion of participants' personal experiences with emotional abuse, followed by psychoeducation covering the definition, forms (e.g., verbal abuse, gaslighting, control, isolation, intimidation), and signs of emotional abuse, as well as its short- and long-term consequences and available prevention and support resources. In the second part, participants completed exercises to identify relational triggers, associated emotions, and potential consequences of maladaptive coping strategies.

In the third session, participants explored how emotional abuse can shape self-concept and reinforce cognitive distortions. A psychoeducational component addressed

how these distortions perpetuate negative emotions, low self-esteem, and maladaptive behaviors. Participants were introduced to cognitive restructuring techniques and practiced identifying and reframing distorted thoughts. They also began monitoring their self-talk using structured logs, supported by the *Self-Conceptualizations Sheet*, *Informative Cognitive Distortion Sheet*, and *Cognitive Restructuring Techniques Sheet*.

The fourth session focused on defining healthy and unhealthy boundaries, their role in relationships, and strategies for setting and maintaining them. In the second part, participants learned about communication styles (passive, aggressive, passive-aggressive) and engaged in role-play exercises to practice assertive communication.

In fifth session, participants were introduced to mindfulness and grounding techniques to manage intense emotions and improve self-awareness. Exercises included *Be Where You Are* (mindfulness) and *Five Senses* (grounding), as well as an acceptance-based mindfulness practice. Participants also engaged in a coping strategies activity, identifying painful thoughts or feelings, documenting coping strategies used, and rating their effectiveness.

The sixth session discussion focused on identifying signs of healthy and unhealthy relationships, strategies for building trust, and effective communication in future relationships. Participants completed a *Relationship Circles* activity to reflect on relational closeness and trust. Communication skills were further developed through conflict resolution exercises, including identifying communication triggers and practicing "I-statements."

The seventh session emphasized self-care practices, healthy lifestyle habits, and goal setting. The *Ten Valued Domains* exercise encouraged participants to assess the

importance of different life areas (e.g., family, career, health) and evaluate alignment between their values and current actions, promoting meaningful life changes.

The final two sessions were dedicated to reviewing key concepts, consolidating skills, and promoting self-reflection on progress. Participants shared personal experiences, discussed how the program impacted their relationships and daily lives, and provided feedback on the intervention.

Table 1.

Content of the Group Sessions

WEEK	CONTENT	ACTIVITIES
Week 1 Introduction	➢ Introduction ➢ Helping the participants to know each other ➢ Decision on the rules of the group sessions	➢ Ice breaker Activity – Ten Things in Common
Week 2 Building Trust and Establishing Safety	➢ Introduction of the emotional abuse intervention and psychoeducation about emotional abuse, its impact, and the recovery process. ➢ Identify triggers for toxic relationships and recognition of consequences.	➢ Psychoeducation about emotional abuse ➢ A tool for the identification of triggers ➢ Feelings identification ➢ Recognition of consequences
Week 3 Recognizing and Restructuring Negative Self-Beliefs	➢ Identifying self-conceptualizations through Acceptance and Commitment Therapy techniques. ➢ Defining Cognitive Distortions and explaining their influence ➢ Introduction to Monitoring Self-Talk related to women's cognitive distortions and strengthening the	➢ Self-conceptualizations ➢ Informative Cognitive Distortion ➢ Cognitive Restructuring Techniques ➢ Self-Talk Log

	awareness of self-talk and self-esteem	
Week 4 Exploring boundaries and assertiveness	➢ Define and discuss the importance of setting and maintaining boundaries. ➢ Identify personal boundaries and establish guidelines for healthy relationships. ➢ Teach communication skills and techniques to communicate needs effectively. ➢ Role-play scenarios to practice assertive communication.	➢ Setting Boundaries Activities ➢ Saying No Activities Communication Style ➢ Using I-Statements ➢ Role-Play Exercises
Week 5 Emotional Regulation and Coping Strategies	➢ Teach emotional regulation techniques to manage intense emotions (introduce mindfulness and grounding exercises to increase self-awareness) ➢ Identify triggers and develop a personalized coping plan.	➢ Mindfulness Exercise: Be Where You Are ➢ Grounding Exercises: Five Senses ➢ Exercise: What Needs To Be Accepted ➢ Coping Strategies
Week 6 Rebuilding Trust and Developing Healthy Relationships	➢ Discuss the impact of emotional abuse on trust and intimacy. ➢ Help women identify signs of healthy and unhealthy relationships. ➢ Explore strategies for building trust in future relationships. ➢ Guide communication skills and conflict resolution	➢ Communication Skills and Conflict Resolution Activity ➢ Feelings Identification ➢ Trust and Intimacy
Week 7 Reinforcing Resilience and Future Planning	➢ Reinforce strengths and resilience ➢ Encourage self-care practices and healthy lifestyle habits assisting women in setting realistic goals for	➢ Reinforce strengths and resilience: **Ten Valued Domains Exercise**

	the future and creating a support network	➢ Encourage self-care practices and healthy lifestyle habits: **Self-Compassionate Letter and Journaling**
Week 8 Consolidation	➢ Review key concepts and techniques covered throughout the intervention encouraging self-reflection and self-evaluation of progress made ➢ Discuss relapse prevention strategies and create an aftercare plan ➢ Provide additional resources for ongoing support (books, support groups, helplines, etc.).	
Week 9 Closure	Assessment of Emotional Abuse Intervention: ➢ Gathering feedback to determine the program's effectiveness in achieving its predefined goals ➢ Analyzing data and testimonials from participants to gauge the impact of the program on preventing and intervening in emotional abuse **Evaluation of the Psychological Counselor Implementing the Program** **Program Evaluation** **Participant-Driven Evaluation**	

	Ensuring Positive Closure of Group Work **Positive Feedback for Program Participants**	

2.4. Results

Before proceeding with the primaryanalyses, all raw scores obtained from the experimental and control groups were converted into Z-scores to assess whether the homogeneity assumption was satisfied. Inspection of Z-scores indicated that both groups were homogeneous, with no values falling outside the ±3 range. This confirmed the absence of outliers that could bias the results. Consequently, all subsequent analyses were conducted using the original raw scores.

To determine whether significant differences existed between the experimental and control groups across all outcome measures, difference scores (i.e., post-test minus pre-test, and follow-up minus post-test) were computed within each group. This approach allowed for more precise change evaluation over time, minimizing the potential confounding effects of individual baseline differences. Given the approximately two-month interval between pre-test and post-test, difference scores were also used to help control for potential external or environmental influences that could have occurred during this time.

The following statistical procedures were used for hypothesis testing, for examining pre- to post-intervention changes within each group (experimental and control) across multiple dependent variables (e.g., emotion regulation, well-being, and emotional abuse), one-way multivariate analyses of variance (MANOVA) were conducted. This allowed for simultaneous

evaluation of differences across multiple outcome dimensions while controlling for Type I error inflation. For comparing post-test scores between the experimental and control groups, independent samples t-tests were used on the difference scores, evaluating whether the degree of change differed significantly between groups. For examining within-group changes from post-test to follow-up, paired samples t-tests were used separately for the experimental and control groups. This allowed for assessing the durability of the intervention's effects over time.

For the variable of perceived stress, a different approach was applied due to the unidimensional nature of the measure. Specifically, a one-way ANOVA was used to assess pre-post intervention differences in perceived stress for the experimental and control groups separately. Independent samples t-tests were then conducted on the difference scores to compare the extent of stress reduction between the two groups. Paired samples t-tests were also conducted to compare post-test and follow-up stress levels within each group.

These statistical methods allowed for a rigorous, multi-layered analysis of change over time, intervention effects, and group comparisons across the study's key psychological outcomes: perceived stress, psychological well-being, emotion regulation, and emotional abuse.

2.4.1. Cognitive Emotion Regulation Scale

Pre Experimental – Post Experimental Comparisons

A multivariate analysis of variance (MANOVA) was conducted to assess the effect of time (pre- and post-test) within the experimental group across nine cognitive emotion regulation strategies. Descriptive statistics revealed shifts in strategy use from pre- to post-

intervention. For instance, self-blame decreased from a pre-test mean of 3.35 (SD = 0.71) to a post-test mean of 2.65 (SD = 0.55), and a similar decrease was observed in blaming others, which dropped from 4.02 (SD = 0.58) to 3.35 (SD = 0.60). Rumination showed a slight decline, with scores moving from M = 3.02 (SD = 0.49) to M = 2.96 (SD = 0.74). Catastrophizing also decreased from M = 3.00 (SD = 0.98) to M = 2.63 (SD = 0.65). In contrast, some adaptive strategies showed an upward trend following the intervention. Positive refocusing increased from M = 2.90 (SD = 0.97) to M = 3.75 (SD = 0.58), and positive reappraisal rose from M = 2.77 (SD = 0.69) to M = 3.79 (SD = 0.84). Refocus on planning similarly increased from M = 2.92 (SD = 0.53) to M = 3.88 (SD = 0.73), suggesting enhanced use of adaptive regulation strategies after the intervention.

The MANOVA results revealed a statistically significant multivariate effect of time on the combined emotion regulation strategies within the experimental group, Pillai's Trace = .760, $F(9, 14) = 4.93$, $p = .004$, partial $\eta^2 = .760$. This indicates that the intervention had a substantial overall effect on the participants' cognitive emotion regulation profiles. The large effect size further supports the efficacy of the intervention in altering the use of emotion regulation strategies among participants, with notable reductions in maladaptive strategies and increases in adaptive coping mechanisms.

Table 2. Descriptive Statistics Table: Pre- and Post-Test Scores in Experimental Group

Subscale	**Pre-M**	**Pre- SD**	**Post-M**	**Post- SD**
Self-blame	3.35	0.71	2.65	0.55
Other-blame	4.02	0.58	3.35	0.60
Rumination	3.02	0.49	2.96	0.74

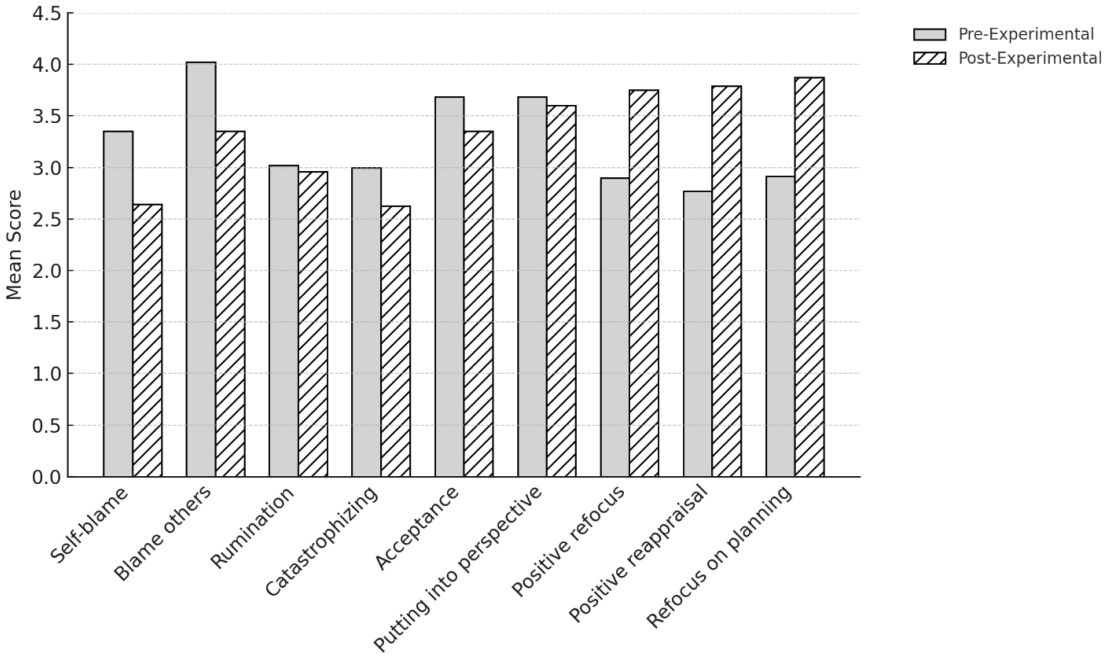
Catastrophizing	3.00	0.98	2.63	0.65
Acceptance	3.69	0.34	3.35	0.90
Putting into perspective	3.69	0.53	3.60	0.66
Positive refocus	2.90	0.97	3.75	0.58
Positive reappraisal	2.77	0.69	3.79	0.84
Refocus on planning	2.92	0.53	3.88	0.73

Note. M = mean; SD = standard deviation.

Table 3. Multivariate Test Results: Pre-Post Differences in Experimental Group

Effect	**Test**	**Value**	**F**	**Hypothesis df**	**Error df**	**p**	**Partial η^2**
Group	Pillai's Trace	0.76	4.93	9	14	.004	.76
Group	Wilks' Lambda	0.24	4.93	9	14	.004	.76
Group	Hotelling's Trace	3.18	4.93	9	14	.004	.76
Group	Roy's Largest Root	3.17	4.93	9	14	.004	.76

Figure 1. Pre- and Post-Test Mean Scores in Experimental Group Across Emotion Regulation Strategies



Pre-Control – Post-Control Comparisons

A multivariate analysis of variance (MANOVA) was conducted to investigate the impact of a control condition over time by comparing pre- and post-test scores on nine cognitive emotion regulation strategies. Descriptive statistics indicated changes in mean scores from pre- to post-test across several variables. For example, self-blame scores increased from pre-test (M = 2.00, SD = 0.00) to post-test (M = 2.92, SD = 0.76), suggesting a rise in the use of this maladaptive strategy over time in the control group. Similarly, blaming others increased from M = 3.17 (SD = 0.94) to M = 3.98 (SD = 0.51), while rumination decreased from M = 3.79 (SD = 0.55) to M = 2.52 (SD = 0.75), indicating some variability in emotional regulation tendencies across time. Catastrophizing scores slightly decreased from M = 3.08 (SD = 0.64) to M = 2.67 (SD = 0.79), and acceptance remained relatively stable (Pre: M = 2.63, SD = 0.78; Post: M = 2.88, SD = 0.65). In contrast, some adaptive strategies like positive refocusing and positive reappraisal showed

a downward trend (e.g., posrefocus: Pre: M = 3.33, SD = 0.64; Post: M = 2.71, SD = 0.80), while others, such as putting into perspective (Pre: M = 3.21, SD = 0.68; Post: M = 3.40, SD = 0.89), slightly increased.

The results of the MANOVA revealed a statistically significant multivariate effect of group over time, Pillai's Trace = .872, $F(9, 14) = 10.562$, $p < .001$, partial $\eta^2 = .872$. This finding indicates that the combined dependent variables significantly differed between pre- and post-test conditions within the control group. The large effect size suggests that notable shifts occurred in emotion regulation strategy usage across the time points, even in the absence of an intervention, warranting further investigation into potential contextual or developmental influences affecting participants' regulatory behaviors.

Table 4. Means and Standard Deviations for Pre-Test and Post-Test Scores Within the Control Group

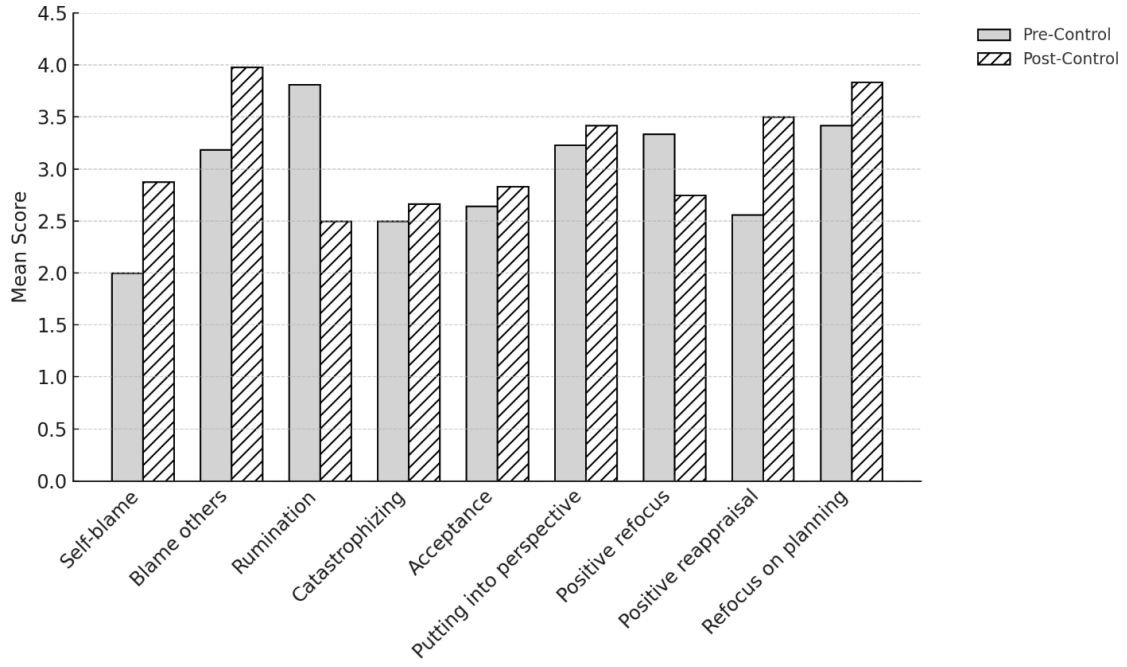
Subscale	Pre-Test M (SD)	Post-Test M (SD)
Self-Blame	2.00 (0.00)	2.92 (0.76)
Blame Other	3.17 (0.94)	3.98 (0.51)
Rumination	3.79 (0.55)	2.52 (0.75)
Catastrophizing	3.08 (0.64)	2.67 (0.79)
Acceptance	2.63 (0.78)	2.88 (0.65)
Putting into Perspective	3.21 (0.67)	3.40 (0.89)
Positive Refocus	3.33 (0.64)	2.71 (0.80)
Positive Reappraisal	2.58 (0.61)	3.50 (0.97)
Refocus on Planning	3.44 (0.78)	3.81 (0.76)

Note. Higher scores indicate greater endorsement of the respective cognitive emotion regulation strategy. M = mean; SD = standart deviation.

Table 5. Multivariate Test Results for Pre-Test and Post-Test Differences Within the Control Group

Effect	**Test**	**Value**	**F**	**Hypothesis df**	**Error df**	**Sig.**	**Partial η^2**
Time (Pre vs. Post)	Pillai's Trace	.87	10.56	9	14	.001	.87
Time (Pre vs. Post)	Wilks' Lambda	.13	10.56	9	14	.001	.87
Time (Pre vs. Post)	Hotelling's Trace	6.79	10.56	9	14	.001	.872
Time (Pre vs. Post)	Roy's Largest Root	6.79	10.56	9	14	.001	.87

Figure 2. Pre- and Post-Test Mean Scores in Control Group Across Emotion Regulation Strategies



Post Experimental – Post Control Comparisons

An independent samples t-test was conducted to compare mean scores between the experimental and control groups. The results indicated no statistically significant difference between the experimental group (M = 0.07, SD = 0.36) and the control group (M = 0.13, SD = 0.40), $t(22) = –0.39$, $p = .699$, 95% CI [–0.38, 0.26].

Levene's test indicated that the assumption of equal variances was met, $F(1, 22) = 0.015$, $p = .905$. The mean difference between the groups was –0.06. The effect size, calculated using Cohen's *d*, was approximately –0.16, indicating a small and non-significant effect.

Table 6. Descriptive Statistics for Group Scores

Group	N	M	SD	SE
Experimental	12	.07	.36	.10
Control	12	.13	.40	.11

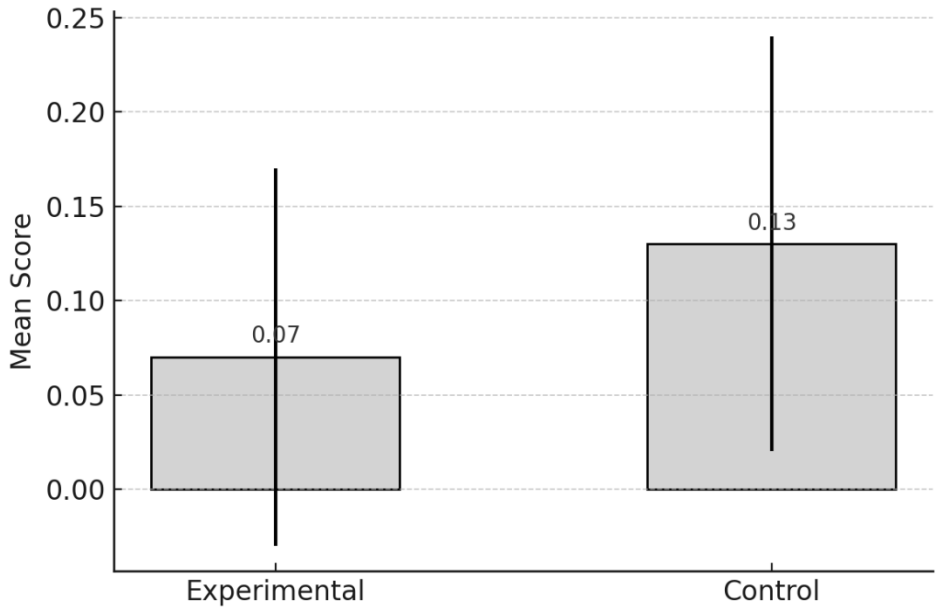
Note. M = Mean; SD = Standard Deviation; SE = Standard Error.

Table 7. Independent Samples t-Test Results

t	df	p	M Diff	SE Diff	95% CI [LL,UL]		Cohen's d
–0.39	22	.699	–0.06	0.15	–0.38	0.26	–0.16

Note. CI = Confidence Interval. Cohen's d calculated using pooled standard deviation.

Figure 3. Comparison of Mean Scores Between Experimental and Control Groups



Follow-up Comparisons

Paired Samples T-test

Two paired samples t-tests were conducted to examine changes in scores from post-test to follow-up within each group.

Experimental Group (Post vs. Follow-Up)

The paired samples t-test revealed a statistically significant decrease in scores from post-test (M = 3.33, SD = 0.27) to follow-up (M = 2.82, SD = 0.46) in the experimental group, t(11) = 3.57, p = .004, 95% CI [0.20, 0.82], d = 1.03. The mean difference was 0.51, suggesting that the intervention may have led to a meaningful reduction in the measured construct (e.g., maladaptive cognitive emotion regulation strategy, depending on the subscale).

Control Group (Post vs. Follow-Up)

For the control group, there was no statistically significant difference between post-test scores (M = 3.15, SD = 0.41) and follow-up scores (M = 2.99, SD = 0.49), t(11) = 0.90, p = .385, 95% CI [–0.22, 0.53], d = 0.26. The small mean difference (M = 0.16) indicates a slight but non-significant change over time.

These findings suggest that the experimental group showed a significant reduction in scores from post-test to follow-up, while the control group did not. This pattern may indicate a positive effect of the intervention, as only the experimental group exhibited significant change. The large effect size in the experimental group (d = 1.03) supports the conclusion that the change was statistically significant and practically meaningful.

Table 8. Descriptive Statistics for Post-Test and Follow-Up Scores

Group	Time Point	N	M	SD	SE
Experimental	Post-Test	12	3.33	0.27	0.08
Experimental	Follow-Up	12	2.82	0.46	0.13
Control	Post-Test	12	3.15	0.41	0.12
Control	Follow-Up	12	3.00	0.49	0.14

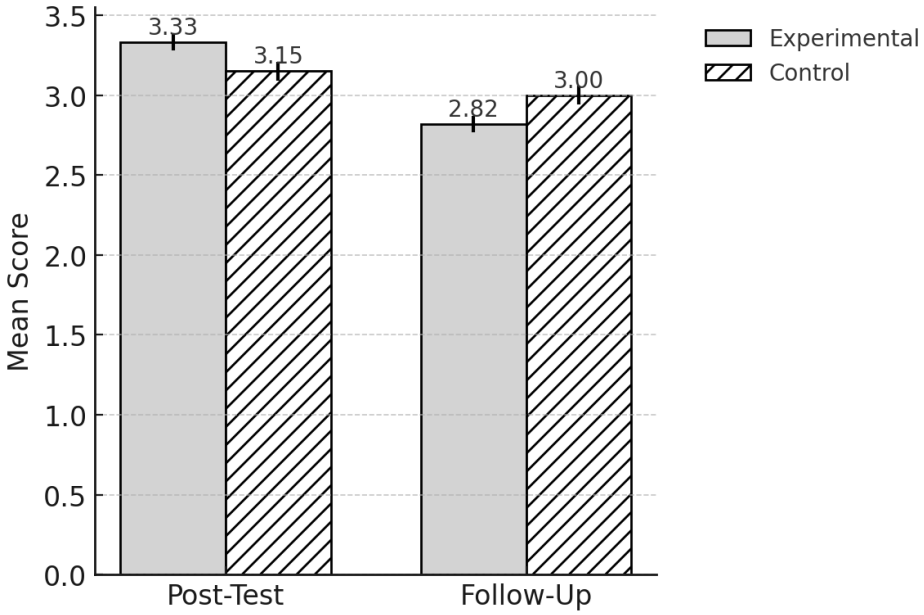
Note. M = Mean; SD = Standard Deviation; SE = Standard Error.

Table 9. Paired Samples t-Test Results

Group	t	df	p	M Diff	SD Diff	SE Diff	95% CI [LL,UL]		Cohen's d
Experimental	3.57	11	.004	0.51	0.49	0.14	0.20	0.82	1.03
Control	0.90	11	.385	0.16	0.59	0.17	–0.22	0.53	0.26

Note. CI = Confidence Interval. Cohen's d calculated using standard deviation of the differences.

Figure 4. Comparison of Post-Test and Follow-Up Scores Between Experimental and Control Groups



2.4.2. Multidimensional Measure of Emotional Abuse

Pre Experimental – Post Experimental Comparisons

A multivariate analysis of variance (MANOVA) was conducted to examine the effect of time (pre- vs. post-test) within the experimental group on eight subdimensions of emotional abuse, including both perpetration and victimization. Descriptive statistics indicated consistent reductions across all subscales from pre- to post-test, suggesting that the intervention may have had a beneficial impact. For perpetration-related dimensions, self-reported rejection decreased from M = 3.45 (SD = 0.99) to M = 2.22 (SD = 0.74), denigration dropped from M = 2.62 (SD = 1.38) to M = 1.68 (SD = 0.70), hostile withdrawal reduced from M = 3.95 (SD = 0.99) to M = 2.86 (SD = 0.84), and intimidation declined from M = 2.44 (SD = 0.84) to M = 2.14 (SD = 1.31). Similarly, reductions were

observed in victimization subdimensions, where rejection decreased from M = 3.24 (SD = 0.77) to M = 2.49 (SD = 1.53), denigration from M = 3.10 (SD = 1.38) to M = 2.23 (SD = 1.69), hostile withdrawal from M = 4.38 (SD = 1.24) to M = 3.19 (SD = 1.18), and intimidation from M = 3.26 (SD = 1.36) to M = 2.49 (SD = 1.39). These reductions in both the perpetration and victimization dimensions highlight potential improvements in emotional regulation and interpersonal functioning following the intervention.

The MANOVA results revealed a marginally non-significant multivariate effect of time on the combined dependent variables, Pillai's Trace = .574, $F(8, 15) = 2.53$, $p = .058$, partial $\eta^2 = .574$. While the p-value slightly exceeds the conventional alpha level of .05, the large effect size suggests that the changes observed may be meaningful and clinically relevant. These findings point to a potential impact of the intervention on reducing emotionally abusive behaviors and experiences, warranting further investigation in larger or more powered samples.

Table 10. Means and Standard Deviations for Perpetration and Victimization Subscales by Group

Subscale	**Experimental Group M (SD)**	**Control Group M (SD)**
Perpetration_RE	3.45 (.99)	2.22 (.74)
Perpetration_Denigration	2.62 (1.38)	1.68 (.70)
Perpetration_HostileWithdrawal	3.95 (.99)	2.86 (.84)
Perpetration_Intimidation	2.44 (.84)	2.14 (1.31)
Victimization_RE	3.24 (.77)	2.49 (1.53)

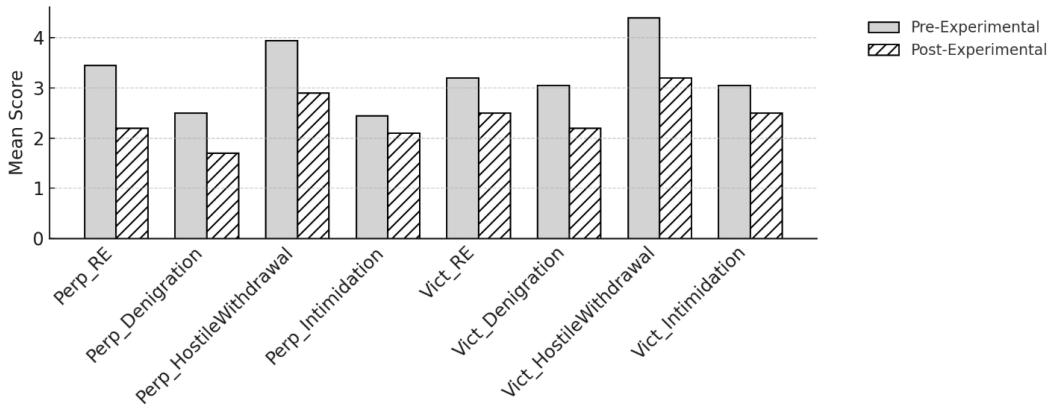
Victimization_Denigration	3.10 (1.38)	2.23 (1.69)
Victimization_HostileWithdrawal	4.38 (1.24)	3.19 (1.18)
Victimization_Intimidation	3.26 (1.36)	2.49 (1.39)

Note. M = mean; SD = standard deviation.

Table 11. Multivariate Test Results for Group Differences Across Perpetration and Victimization Subscales

Effect	Test	Value	F	Hypothesis df	Error df	Sig.	Partial η²
Group	Pillai's Trace	0.574	2.528	8	15	0.058	0.574
Group	Wilks' Lambda	0.426	2.528	8	15	0.058	0.574
Group	Hotelling's Trace	1.348	2.528	8	15	0.058	0.574
Group	Roy's Largest Root	1.348	2.528	8	15	0.058	0.574

Figure 5. Pre- and Post-Test Mean Scores in Experimental Group Across Perpetration and Victimization Subdimensions



Pre-Control – Post-Control Comparisons

A multivariate analysis of variance (MANOVA) was conducted to assess the effect of time (pre- vs. post-test) on the control group's scores across eight subdimensions of emotional abuse, including both perpetration and victimization aspects. Descriptive statistics showed relatively minor changes between the pre- and post-test periods across most subdimensions, suggesting limited natural variation in the absence of an intervention. For perpetration subscales, rejection decreased slightly from M = 2.77 (SD = 0.76) to M = 2.56 (SD = 1.44), denigration remained stable with means of M = 2.01 (SD = 0.56) and M = 2.02 (SD = 1.53), hostile withdrawal decreased marginally from M = 3.07 (SD = 1.02) to M = 2.96 (SD = 1.49), and intimidation stayed nearly unchanged from M = 1.87 (SD = 0.51) to M = 1.87 (SD = 0.87). Regarding victimization, rejection scores dropped from M = 2.50 (SD = 1.39) to M = 1.74 (SD = 0.60), denigration decreased from M = 2.70 (SD = 1.24) to M = 1.63 (SD = 0.60), hostile withdrawal showed a reduction from M = 3.56 (SD = 1.39) to M = 3.05 (SD = 1.60), and intimidation decreased slightly from M = 2.67 (SD = 1.31) to M = 2.49 (SD = 1.66). These results reflect small fluctuations in emotional abuse experiences and behaviors over time within the control group.

The MANOVA results indicated no statistically significant multivariate effect of time on the combined dependent variables, Pillai's Trace = .395, $F(8, 15) = 1.23$, $p = .349$, partial $\eta^2 = .395$. Although the effect size is moderate, the lack of statistical significance suggests that the changes observed in the control group are likely attributable to chance rather than systematic variation. This supports the notion that, without an intervention, levels of emotional abuse tend to remain relatively stable across time.

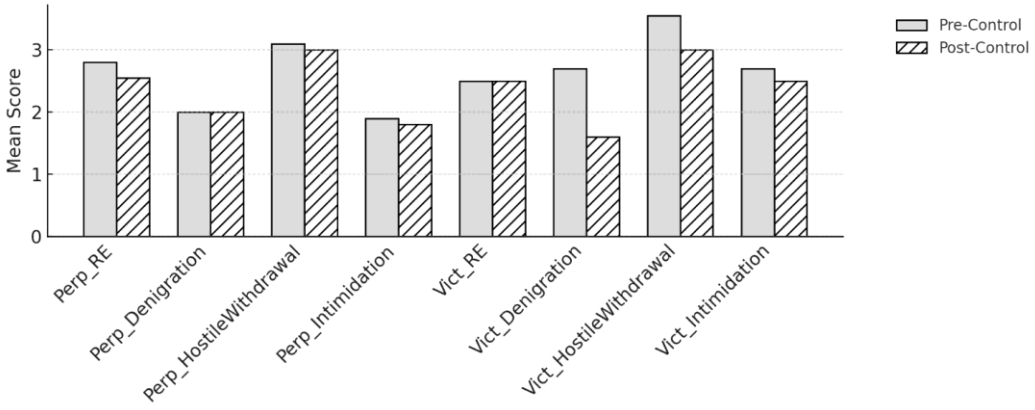
Table 12. Means and Standard Deviations for Perpetration and Victimization Subscales by Pre- and Post-Control Groups

Subscale	Pre-Control M (SD)	Post-Control M (SD)
Perpetration_RE	2.77 (.76)	2.56 (1.44)
Perpetration_Denigration	2.01 (.56)	2.02 (1.53)
Perpetration_HostileWithdrawal	3.07 (1.02)	2.96 (1.49)
Perpetration_Intimidation	1.87 (.51)	1.87 (.87)
Victimization_RE	2.50 (1.39)	1.74 (.60)
Victimization_Denigration	2.70 (1.24)	1.63 (.60)
Victimization_HostileWithdrawal	3.56 (1.39)	3.05 (1.59)
Victimization_Intimidation	2.67 (1.31)	2.49 (1.66)

Table 13. Multivariate Test Results for Pre-Post Differences in Control Group Across Perpetration and Victimization Subdimensions

Effect	Test	Value	F	Hypothesis df	Error df	Sig.	Partial η^2
Group	Pillai's Trace	.39	1.22	8	15	.34	0.39
Group	Wilks' Lambda	.60	1.22	8	15	.34	0.39
Group	Hotelling's Trace	.65	1.22	8	15	.34	0.39
Group	Roy's Largest Root	.65	1.22	8	15	.34	0.39

Figure 6. Pre- and Post-Test Mean Scores in Control Group Across Perpetration and Victimization Subdimensions



Post Experimental – Post Control Comparisons

An independent samples t-test was conducted to compare the mean scores between the experimental and control groups. There was no significant difference in scores between the experimental group (M = 2.64, SD = 0.62) and the control group (M = 2.29, SD = 0.86); t(22) = 1.16, p = .261, d = 0.47. The 95% confidence interval for the mean difference ranged from -0.28 to 0.99. Levene's test indicated that the assumption of equal variances was met, $F(1, 22) = 0.89$, $p = .355$.

Table 14. Descriptive Statistics for Experimental and Control Groups

Group	N	M	SD	SE
Experimental	12	2.64	0.62	0.18
Control	12	2.29	0.86	0.25

Note. M = Mean; SD = Standard Deviation; SE = Standard Error.

Table 15. Independent Samples t-Test Results Comparing Experimental and Control Groups

Levene's F	p (Levene)	t	df	p	Mean Diff.	SE Diff.	95% CI [LL,UL]		Cohen's d
0.89	.355	1.16	22	.261	0.35	0.31	-0.28	0.99	0.47

Note. Equal variances assumed. CI = Confidence Interval.

Follow-up Comparisons

Paired Samples T-test

Two paired samples t-tests were conducted to examine how scores changed from post-test to follow-up within each group.

Experimental Group (Post vs. Follow-Up)

A paired samples t-test revealed that there was no statistically significant difference between the post-test scores (M = 2.41, SD = 0.86) and follow-up scores (M = 2.11, SD = 0.54) in the experimental group, t(11) = 1.07, p = .307, 95% CI [-0.31, 0.91], d = 0.31.

The mean difference (M = 0.30) was not large enough to reach statistical significance, suggesting that the effects observed immediately after the intervention were maintained but did not continue to significantly change over time.

Control Group (Post vs. Follow-Up)

In contrast, the control group showed a statistically significant increase in scores from post-test (M = 2.29, SD = 0.86) to follow-up (M = 3.00, SD = 0.38), t(11) = -2.42, p = .034, 95% CI [-1.36, -0.06], d = -0.70. The mean increase (M = -0.71) indicates that the control group experienced

a notable change between time points, suggesting a potential worsening of the measured construct (depending on what higher scores represent, e.g., more symptoms, higher risk, etc.).

These findings indicate that while the experimental group maintained their post-test levels at follow-up, the control group exhibited a significant deterioration. This pattern implies a protective effect of the intervention, as the experimental group's scores remained stable whereas the control group's outcomes worsened over time.

Table 16. Descriptive Statistics for Post-Test and Follow-Up Scores

Group	Time Point	N	M	SD	SE
Experimental	Post-Test	12	2.41	0.86	0.25
Experimental	Follow-Up	12	2.11	0.54	0.16
Control	Post-Test	12	2.29	0.86	0.25
Control	Follow-Up	12	3.00	0.38	0.11

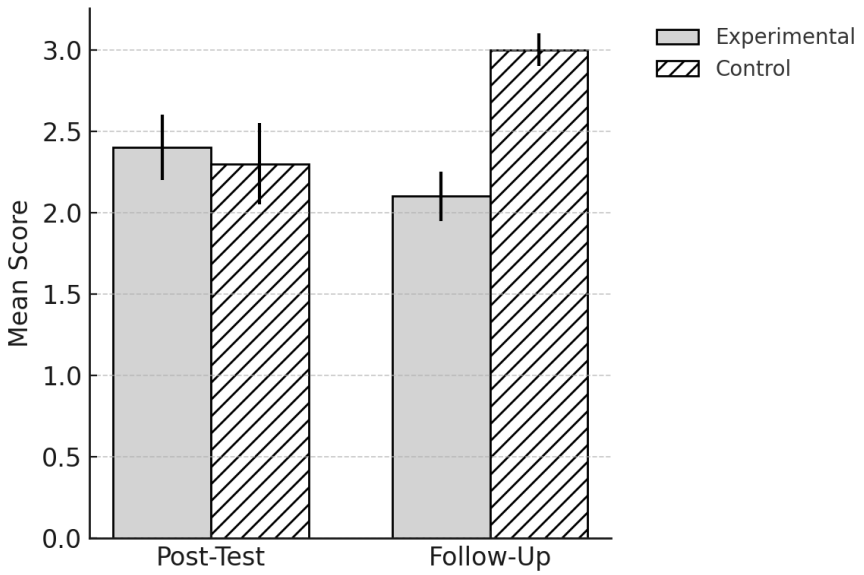
Note. M = Mean; SD = Standard Deviation; SE = Standard Error.

Table 17. Paired Samples t-Test Results

Group	t	df	p	Mean Diff.	SD Diff.	SE Diff.	95% CI [LL,UL]		Cohen's d
Experimental	1.07	11	.307	0.30	0.96	0.28	-0.31	0.91	0.31
Control	-2.42	11	.034	-0.71	1.02	0.30	-1.36	-0.06	-0.70

Note. CI = Confidence Interval. Cohen's d is calculated using the mean difference divided by the SD of differences.

Figure 7. Post-Test and Follow-Up Scores by Group



2.4.3. PERMA Measure

Pre Experimental – Post Experimental Comparisons

A multivariate analysis of variance (MANOVA) was conducted to examine the effect of time (pre- vs. post-test) within the experimental group on eight psychological dimensions: P_score, E_score, R_score, M_score, A_score, H_score, N_score, and L_score. Descriptive statistics indicated consistent increases across all measured scores following the intervention. Specifically, P_score increased from M = 6.17 (SD = 0.55) to M = 6.42 (SD = 1.62), and E_score increased from M = 6.17 (SD = 0.78) to M = 7.31 (SD = 1.71). Similarly, R_score rose from M = 5.61 (SD = 1.82) to M = 7.08 (SD = 1.83), and M_score from M = 5.19 (SD = 1.62) to M = 6.94 (SD = 1.90). A_score demonstrated a similar trend, rising from M = 5.61 (SD = 0.72) to M = 7.33 (SD = 1.94), while H_score increased from M = 4.94 (SD = 1.94) to M = 7.83 (SD = 1.91). N_score and L_score also showed upward trends, with N_score moving from M = 5.83 (SD = 1.46) to M = 6.75 (SD

= 1.56), and L_score from M = 3.33 (SD = 2.09) to M = 4.17 (SD = 2.41). These consistent increases suggest a positive shift across various psychological parameters of post-intervention.

The MANOVA results revealed a marginally non-significant multivariate effect of time on the combined dependent variables, Pillai's Trace = .575, $F(8, 15) = 2.542$, $p = .057$, partial $\eta^2 = .575$. While the p-value falls just above the conventional threshold of significance ($p < .05$), the effect size is large, indicating that the observed differences may still be of practical importance. These findings suggest that the intervention may have led to meaningful improvements in the measured psychological dimensions, warranting further exploration in studies with larger sample sizes.

Table 18. Means and Standard Deviations for Pre-Experimental and Post-Experimental Scores

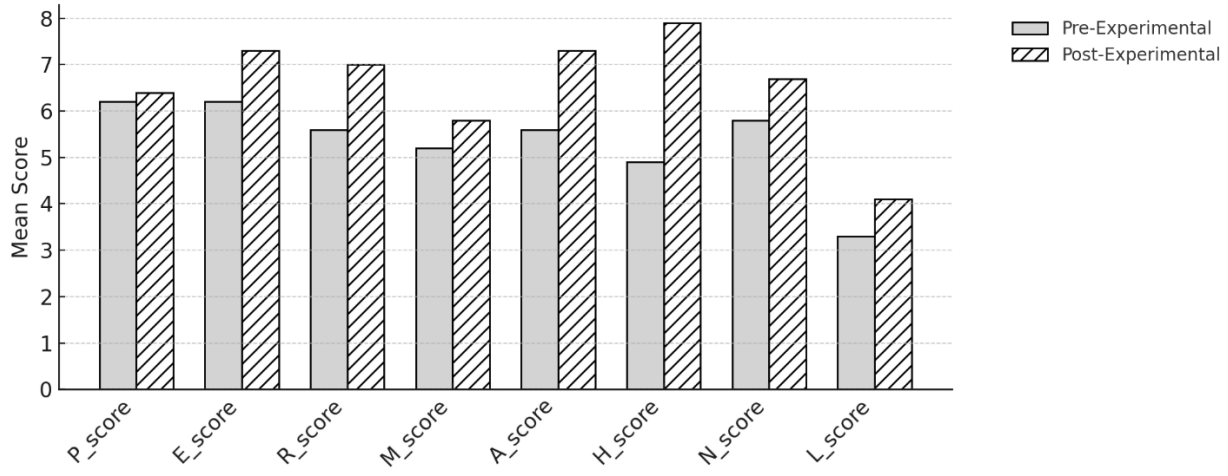
Subscale	Pre-Experimental M (SD)	Post-Experimental M (SD)
P_score	6.17 (0.78)	7.31 (1.71)
E_score	6.17 (0.78)	7.31 (1.71)
R_score	5.61 (1.82)	7.08 (1.83)
M_score	5.19 (1.62)	6.94 (1.90)
A_score	5.61 (.72)	7.33 (1.94)
H_score	4.94 (1.94)	7.33 (1.91)
N_score	5.83 (1.46)	4.75 (1.56)
L_score	5.08 (2.91)	4.17 (2.41)

Note. Higher scores reflect greater endorsement of the respective well-being dimension, except for negative emotion and loneliness where lower scores indicate better outcomes.

Table 19. Multivariate Test Results for Pre-Post Differences in Experimental Group

Effect	Test	Value	F	Hypothesis df	Error df	Sig.	Partial η^2
Group	Pillai's Trace	.57	2.54	8	15	.05	.57
Group	Wilks' Lambda	.42	2.54	8	15	.05	.57
Group	Hotelling's Trace	1.35	2.54	8	15	.05	.57
Group	Roy's Largest Root	1.35	2.54	8	15	.05	.57

Figure 8. Comparison of Pre- and Post-Experimental Mean Scores Across Outcome Dimensions



Pre-Control – Post-Control Comparisons

A multivariate analysis of variance (MANOVA) was conducted to evaluate changes over time in the control group across eight psychological dimensions: P_score, E_score, R_score, M_score, A_score, H_score, N_score, and L_score. Descriptive statistics revealed relatively minor changes between the pre- and post-test phases. For example, the

mean P_score slightly increased from M = 6.39 (SD = 1.59) to M = 6.97 (SD = 1.85), and E_score from M = 6.78 (SD = 1.91) to M = 8.11 (SD = 1.67). R_score exhibited a small decrease from M = 6.28 (SD = 1.32) to M = 6.56 (SD = 2.14), while M_score increased from M = 6.22 (SD = 2.06) to M = 6.89 (SD = 1.91). A_score rose from M = 6.78 (SD = 1.83) to M = 7.39 (SD = 1.73), and H_score from M = 7.00 (SD = 1.93) to M = 6.36 (SD = 2.18), indicating a slight decrease. The N_score decreased from M = 5.44 (SD = 1.95) to M = 5.17 (SD = 1.49), and L_score increased from M = 4.33 (SD = 2.46) to M = 5.17 (SD = 2.50). These descriptive trends suggest subtle fluctuations in scores over time within the control group.

The MANOVA results indicated no statistically significant multivariate effect of time on the combined dependent variables, Pillai's Trace = .284, $F(8, 15) = 0.742$, $p = .655$, partial $\eta^2 = .284$. Although the effect size was moderate, the non-significant p-value suggests that the observed differences in scores between the pre- and post-test conditions in the control group were likely due to random variation rather than systematic change. These findings support the conclusion that, psychological dimension scores remained largely stable over time in the absence of an intervention.

Table 20. Means and Standard Deviations for Pre-Control and Post-Control Scores

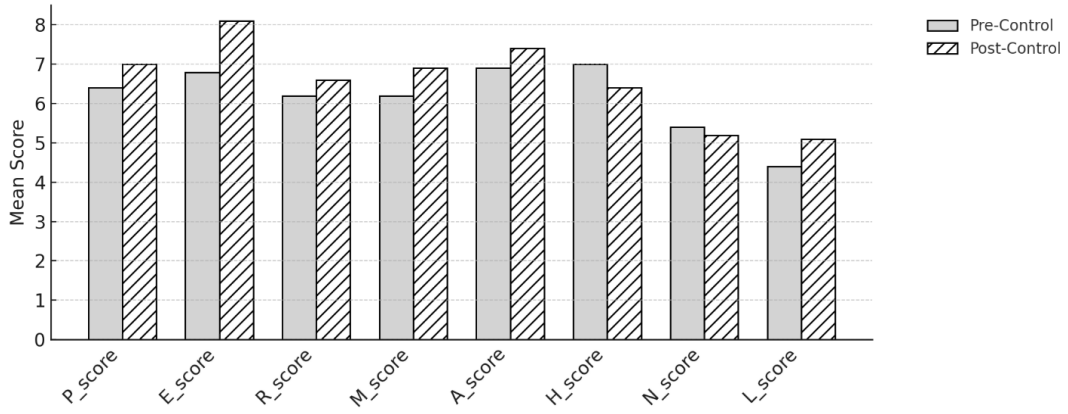
Subscale	Pre-Control M (SD)	Post-Control M (SD)
P_score	6.39 (1.59)	6.97 (1.85)
E_score	6.78 (1.92)	8.11 (1.68)
R_score	6.28 (1.32)	6.56 (2.14)
M_score	6.25 (2.06)	6.89 (1.88)

A_score	6.78 (1.89)	7.39 (1.73)
H_score	7.00 (1.93)	6.36 (2.18)
N_score	5.44 (1.95)	6.08 (1.47)
L_score	4.33 (2.46)	5.17 (2.52)

Table 21. Multivariate Test Results for Pre-Post Differences in Control Group

Effect	**Test**	**Value**	**F**	**Hypothesis df**	**Error df**	**Sig.**	**Partial η²**
Group	Pillai's Trace	.28	.74	8	15	.65	.28
Group	Wilks' Lambda	.72	.74	8	15	.65	.28
Group	Hotelling's Trace	.40	.74	8	15	.65	.28
Group	Roy's Largest Root	.40	.74	8	15	.65	.28

Figure 9. Pre- and Post-Test Mean Scores in Control Group



Post Experimental – Post Control Comparisons

An independent samples t-test was conducted to compare post-test scores between the experimental and control groups. The results indicated that there was no statistically significant difference between the two groups, $t(22) = 0.76$, $p = .458$, 95% CI [–0.97, 2.08]. The experimental group (M = 1.09, SD = 1.43) scored slightly higher than the control group (M = 0.53, SD = 2.11), with a mean difference of 0.56 points.

Levene's test for equality of variances was not significant, $F(1, 22) = 2.35$, $p = .139$, indicating that the assumption of homogeneity of variances was met. The effect size, calculated using Cohen's *d*, was approximately 0.31, suggesting a small and non-significant effect in favor of the experimental group.

Overall, the findings suggest that while the experimental group demonstrated marginally higher post-test scores, this difference was not statistically significant, and there is no sufficient evidence to conclude that the intervention had an immediate impact compared to the control condition.

Table 22. Descriptive Statistics for Post-Test Scores

Group	N	M	SD	SE
Experimental	12	1.09	1.43	0.41
Control	12	0.53	2.11	0.61

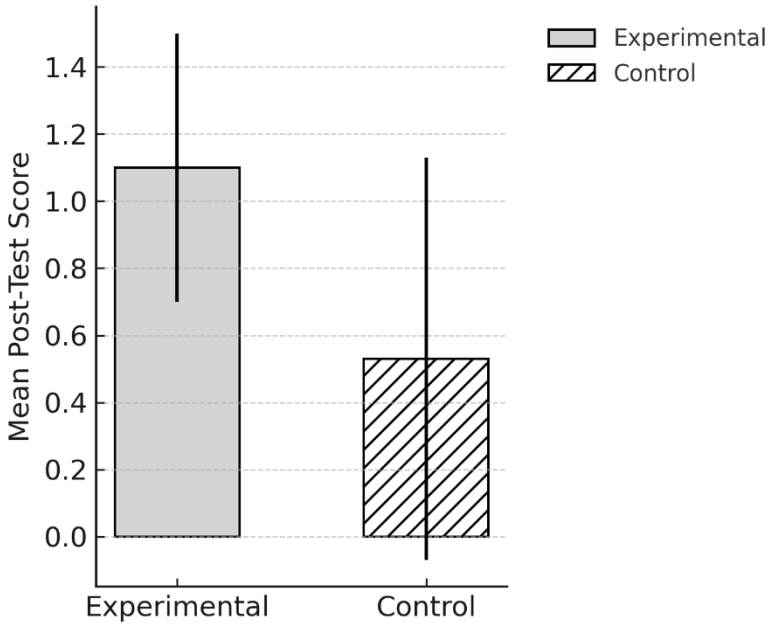
Note. M = Mean; SD = Standard Deviation; SE = Standard Error.

Table 23. Independent Samples t-Test Results

t	df	p	Mean Difference	SE Difference	95% CI [LL,UL]		Cohen's d
0.76	22	.46	.56	.74	-.97	2.08	.31

Note. CI = Confidence Interval. Cohen's d calculated using pooled standard deviation.

Figure 10. Post-Test Scores by Group



Follow-up Comparisons

Two paired samples t-tests were conducted to examine how scores changed from post-test to follow-up within each group.

Experimental Group (Post vs. Follow-Up)

A paired samples t-test revealed that there was no statistically significant difference between post-test scores (M = 6.57, SD = 1.15) and follow-up scores (M = 6.03, SD = 0.84) in the experimental group, t(11) = 1.50, p = .161, 95% CI [–0.25, 1.34], d = 0.43.

The mean difference (M = 0.55) was not large enough to reach statistical significance, suggesting that the gains observed immediately after the intervention were only partially sustained and did not continue to improve significantly over time.

Control Group (Post vs. Follow-Up)

Similarly, the control group showed no statistically significant change in scores from post-test (M = 6.69, SD = 1.22) to follow-up (M = 7.21, SD = 0.73), t(11) = –1.12, p = .289, 95% CI [–1.55, 0.51], d = –0.32. Although the mean difference (M = –0.52) indicated a slight increase in scores over time, this change was not statistically significant.

These findings suggest that neither the experimental nor the control group exhibited significant changes in PERMA scores from post-test to follow-up. While the experimental group showed a small decline and the control group slightly increased, these fluctuations were not statistically meaningful. Therefore, the intervention's long-term effects on psychological well-being, as measured by PERMA, remain inconclusive in this sample.

Table 24. Descriptive Statistics for Post-Test and Follow-Up Scores

Group	Time Point	N	M	SD	SE
Experimental	Post-Test	12	6.57	1.15	0.33
Experimental	Follow-Up	12	6.03	0.84	0.24
Control	Post-Test	12	6.69	1.22	0.35
Control	Follow-Up	12	7.21	0.73	0.21

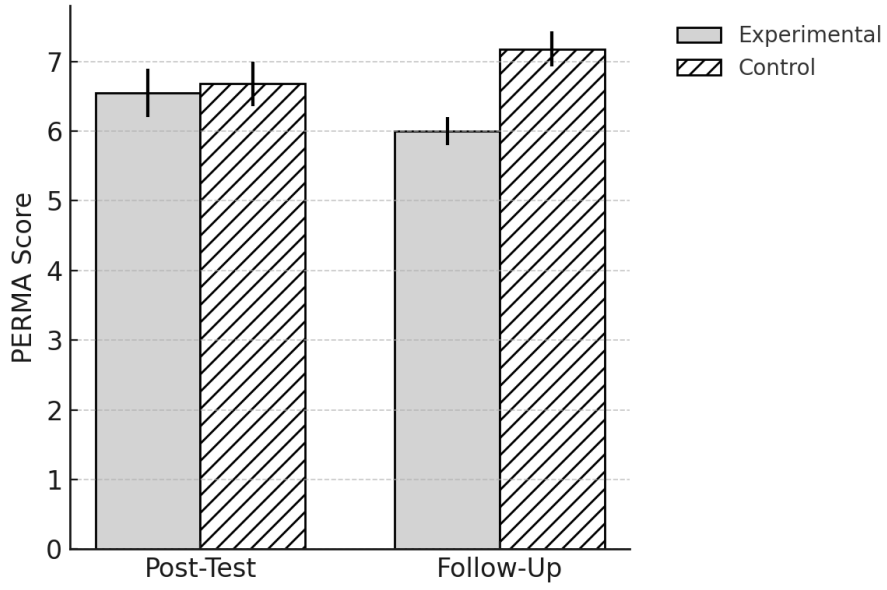
Note. M = Mean; SD = Standard Deviation; SE = Standard Error.

Table 25. Paired Samples t-Test Results

Group	t	df	p (2-tailed)	Mean Diff	SD Diff	SE Difference	95% CI [LL,UL]		Cohen's d
Experimental	1.50	11	.161	.55	1.26	0.36	–0.25	1.34	0.43
Control	–1.12	11	.289	–0.52	1.62	0.47	–1.55	.51	–0.32

Note. CI = Confidence Interval. Cohen's d is calculated as the mean difference divided by standard deviation of the difference.

Figure 11. PERMA Post-Test and Follow-Up Scores by Group



2.4.4. Perceived Stress

Pre Experimental – Post Experimental Comparisons

A one-way between-subjects ANOVA was conducted to compare the effect of the intervention on perceived stress levels in the pre-experimental and post-experimental

groups. The descriptive statistics revealed that the mean perceived stress score decreased from 3.40 (SD = 0.30) in the pre-experimental group to 2.92 (SD = 0.30) in the post-experimental group. The results of the ANOVA indicated a statistically significant difference between groups, $F(1, 22) = 15.60$, $p = .001$, partial $\eta^2 = .415$, suggesting that the intervention substantially reduced perceived stress. The model explained 41.5% of the variance in stress scores, as indicated by the R^2 value.

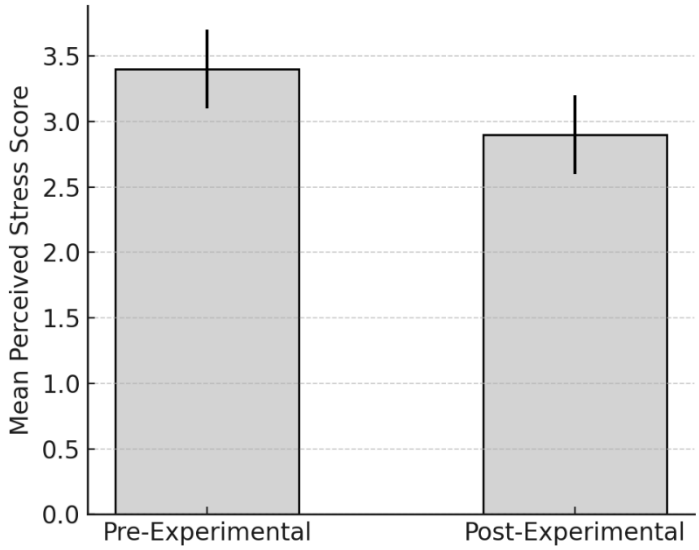
Table 26. Descriptive Statistics for Perceived Stress Scores by Group

Group	Mean	Std. Deviation	N
Pre-Experimental	3.4	.30	12
Post-Experimental	2.92	.30	12
Total	3.16	.38	24

Table 27. Analysis of Variance (ANOVA) Summary for Perceived Stress Scores

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial η^2
Corrected Model	1.40	1	1.40	15.6	.001	.41
Intercept	239.40	1	239.40	2664.504	0	.99
Group	1.40	1	1.40	15.6	.001	.41
Error	1.97	22	.09			
Total	242.78	24				
Corrected Total	3.38	23				

Figure 12. Mean Perceived Stress Scores



Pre-Control – Post-Control Comparisons

A one-way between-subjects analysis of variance (ANOVA) was conducted to evaluate whether there were significant differences in perceived stress levels between participants in the pre-control and post-control conditions. The descriptive statistics revealed that the mean perceived stress score for the pre-control group was 3.46 (SD = 0.30), while the post-control group had a mean score of 3.33 (SD = 0.35), indicating a slight decrease in stress levels over time.

Despite this numerical reduction, the ANOVA results showed that the difference between the two groups was not statistically significant, $F(1, 22) = 0.89$, $p = .356$. As measured by partial η^2, the effect s, was small ($\eta^2 = .039$), suggesting that only 3.9% of the variance in stress scores could be attributed to the group factor. Furthermore, the model accounted for a minimal proportion of the overall variance, with an R^2 value of .039 and an adjusted R^2 of −.005, indicating limited explanatory power. These findings suggest that

in the absence of an active intervention, the perceived stress levels of participants in the control group remained relatively stable across time.

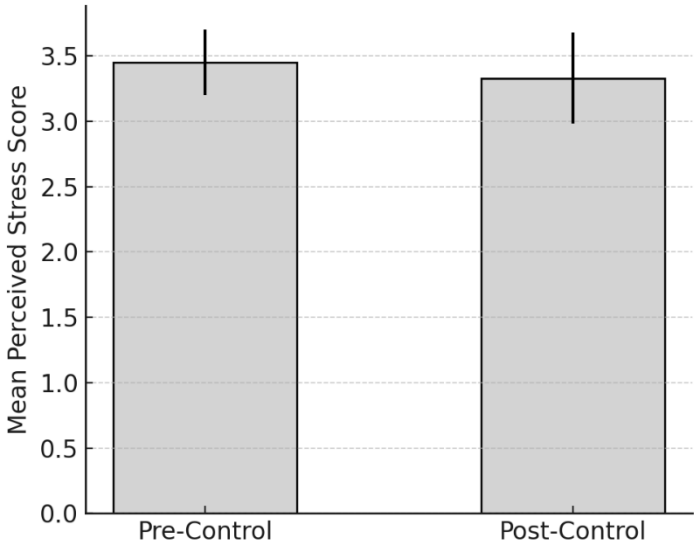
Table 28. Descriptive Statistics Table by Group

Group	Mean	Std. Deviation	N
Pre-Control	3.46	.30	12
Post-Control	3.33	.35	12
Total	3.40	.32	24

Table 29. Analysis of Variance (ANOVA) Summary for Perceived Stress Scores

Source	Type III Sum of Squares	df	Mean Square	F	p	Partial η^2
Corrected Model	.094	1	0.09	.90	.36	.03
Intercept	276.76	1	276.76	2629.174	0	.99
Group	.09	1	.094	0.90	0.36	.04
Error	2.32	22	.105			
Total	279.17	24				
Corrected Total	2.41	23				

Figure 13. Mean Perceived Stress Scores For The Pre-Control and Post-Control Groups



Post Experimental – Post Control Comparisons

An independent samples t-test was conducted to compare the scores between the experimental and control groups. The results indicated a statistically significant difference between the experimental group (M = –0.52, SD = 0.57) and the control group (M = –0.01, SD = 0.43), $t(22) = -2.48$, $p = .021$, 95% CI [–0.93, –0.08].

The experimental group had significantly lower scores than the control group, with a mean difference of –0.51 points. Levene's test for equality of variances was not significant, $F(1, 22) = 1.57$, $p = .223$, indicating that the assumption of homogeneity of variances was met. The effect size, calculated using Cohen's *d*, was approximately –1.00, representing a large effect size.

Table 30. Descriptive Statistics for Group Scores

Group	N	M	SD	SE
Experimental	12	–0.52	0.57	0.16
Control	12	–0.01	0.43	0.12

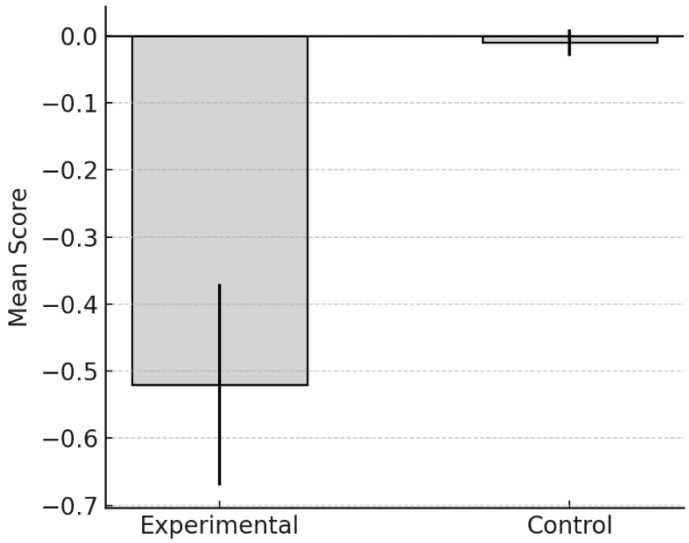
Note. M = Mean; SD = Standard Deviation; SE = Standard Error.

Table 31. Independent Samples t-Test Results

t	df	p	Mean Diff	SE Diff	95% CI [LL,UL]		Cohen's d
–2.48	22	.021	–0.51	0.21	–0.93	–0.08	–1.00

Note. CI = Confidence Interval. Cohen's d calculated using pooled standard deviation.

Figure 14. Comparison of Group Scores on Outcome Measure



Follow-up Comparisons

To examine how scores changed from post-test to follow-up within each group, two paired samples t-tests were conducted.

Experimental Group (Post vs. Follow-Up)

A paired samples t-test revealed that there was no statistically significant difference between post-test scores (M = 3.39, SD = 1.14) and follow-up scores (M = 3.19, SD = 1.06) in the experimental group, $t(11) = 1.06$, $p = .313$, 95% CI [–0.21, 0.61], $d = 0.31$. The mean difference (M = 0.20) was small and non-significant, indicating that stress levels in the experimental group remained relatively stable between post-test and follow-up.

Control Group (Post vs. Follow-Up)

Similarly, the control group showed no statistically significant change in scores from post-test (M = 3.33, SD = 1.10) to follow-up (M = 3.43, SD = 1.18), $t(11) = –0.29$, $p = .777$, 95% CI [–0.65, 0.45], $d = –0.09$. The mean difference (M = –0.10) suggests a slight but statistically non-significant increase in stress over time in the control group.

These findings suggest that stress levels did not significantly change from post-test to follow-up in either group. While the experimental group experienced a small, non-significant decrease and a slight increase in the control group, neither change reached statistical significance. Therefore, based on these results, no definitive conclusions can be drawn regarding the intervention's long-term impact on stress.

Table 32. Descriptive Statistics for Post-Test and Follow-Up Stress Scores

Group	Time Point	N	M	SD	SE
Experimental	Post-Test	12	3.39	1.14	0.33
Experimental	Follow-Up	12	3.19	1.06	0.30

Control	Post-Test	12	3.33	1.10	0.32
Control	Follow-Up	12	3.43	1.18	0.34

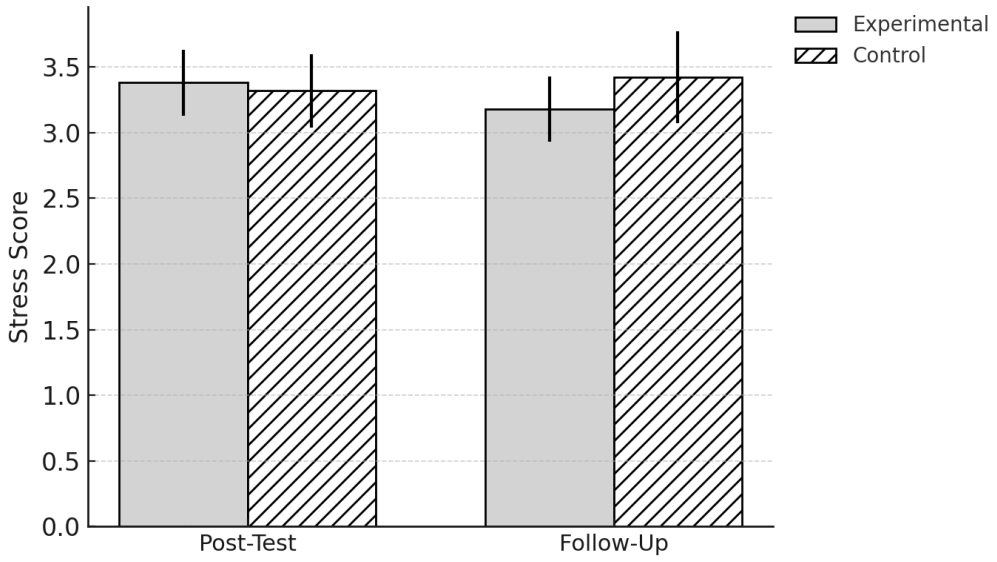
Note. M = Mean; SD = Standard Deviation; SE = Standard Error.

Table 33. Paired Samples t-Test Results for Stress Scores

Group	t	df	p	M Diff	SD Diff	SE Diff	95% CI [LL,UL]		Cohen's d
Experimental	1.06	11	.313	0.20	0.61	0.19	–0.21	0.61	0.31
Control	–0.29	11	.777	–0.10	1.00	0.35	–0.65	0.45	–0.09

Note. CI = Confidence Interval. Cohen's d calculated using standard deviation of the differences.

Figure 15. Stress Scores at Post-Test and Follow-Up by Group



2.5. Discussion

The primary aim of this study was to develop and evaluate a culturally adapted, group-based intervention combining Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT) for women in Türkiye who had experienced emotional abuse (EA) in intimate relationships. As noted in the introduction, EA is one of the most pervasive yet least visible forms of intimate partner violence (IPV), often normalized in the Turkish context and underrepresented in intervention research, which underscores the need for theoretically grounded, skills-based programs that can be implemented in real-world settings (MoFSP, 2014). The intervention targeted perceived stress, psychological well-being, emotion regulation, and emotional abuse (perpetration and victimization), with the expectation—grounded in CBT's efficacy for reshaping maladaptive cognitions and affect (Beck, 2011; Resick et al., 2012; Eckhardt et al., 2013) and ACT's emphasis on psychological flexibility and values-based living (Hayes, 2004; Luoma et al., 2007)—that participants in the experimental group would show greater improvement than controls and maintain gains at follow-up. The findings partially supported these hypotheses and provide compelling evidence for the intervention's efficacy in promoting psychological resilience and emotional self-regulation across multiple outcome domains. With regard to emotion regulation, a primary target of the intervention, the experimental group exhibited a robust multivariate effect (Pillai's Trace = .760, $p = .004$) marked by reductions in maladaptive strategies (self-blame, blaming others, catastrophizing) and increases in adaptive strategies (positive refocusing, positive reappraisal, planning). These shifts align closely with cognitive-behavioral models and the CERQ literature showing that targeted cognitive restructuring and skills practice can modify entrenched regulation patterns implicated in distress (Garnefski et al., 2001; Resick et al., 2012; Eckhardt et al., 2013). They are also

consistent with ACT's cognitive defusion and present-moment awareness processes, which change one's relationship to difficult internal events and reduce perseverative responses like rumination and catastrophizing (Hayes, 2004; Luoma et al., 2007). Although the control group also showed a significant multivariate effect (Pillai's Trace = .87, $p < .001$), its pattern was inconsistent and in some cases regressive (e.g., increases in self-blame), suggesting natural variation or contextual stressors rather than skill-driven change; critically, follow-up analyses indicated sustained improvements for the experimental group ($p = .004$, $d = 1.03$) with no significant change in controls ($p = .385$), strengthening causal attribution to the structured CBT–ACT program rather than time alone. For emotional abuse outcomes, the intervention was associated with reductions across all perpetration and victimization subdimensions; at the sametime, the multivariate test narrowly missed conventional significance ($p = .058$), the large effect size (partial $\eta^2 = .57$) suggests practical importance and coheres with evidence that improving emotion regulation diminishes both the enactment and tolerance of psychologically aggressive behaviors within relationships (Follingstad & Rogers, 2014; Jordan et al., 2010). That the control group showed no significant pre–post change ($p = .35$) and significantly worsened by follow-up ($p = .034$), whereas the experimental group maintained gains, mirrors prior trials where structured, skills-based interventions buffered against relapse into coercive dynamics, even when immediate between-group post-tests were underpowered (Tirado-Muñoz et al., 2014). Psychological well-being (PERMA) demonstrated consistent post-intervention improvements in the experimental group—particularly in positive emotion, meaning, accomplishment, and happiness—with a multivariate effect that approached significance ($p = .057$) and a large effect size (partial $\eta^2 = .575$), which is theoretically

consonant with ACT's values and committed action as drivers of flourishing as well as CBT's behavioral activation and problem-solving components (Seligman, 2011; Luoma et al., 2007; Resick et al., 2012). The absence of further gains at follow-up in either group suggests that booster sessions may be necessary for continued growth in eudaimonic and hedonic well-being, a pattern echoed in trauma-focused interventions where skills are retained but flourishing often requires ongoing support or practice opportunities (Perez & Johnson, 2008). Perceived stress showed the clearest and most statistically robust effects: significant pre–post reduction in the experimental group ($p = .001$, partial $\eta^2 = .415$) and lower post-test stress than controls ($p = .021$, $d = -1.00$). This dovetails with theory and evidence positioning stress both as a consequence and mediator of IPV-related psychopathology—including PTSD, anxiety, and depression—and highlights the dual value of cognitive restructuring and mindfulness/acceptance practices for downregulating stress responses (Reivich & Shatté, 2002; Banks et al., 2015; Pitt et al., 2020). Maintenance of reduced stress at follow-up without additional improvement suggests durable initial effects that could be extended through periodic reinforcement. Taken together, the pattern—strongest and most consistent changes in emotion regulation and stress, supportive but less conclusive evidence in relational functioning and well-being—aligns with the broader literature on CBT and ACT with trauma-exposed or relationally victimized populations, which often shows early cognitive–affective gains that precede or enable broader interpersonal and flourishing outcomes (Dutton, 1992; Tirado-Muñoz et al., 2014; Mahmoudpour et al., 2021; Valizadeh & Ahmadi, 2022). The observation that emotional abuse indices stabilized in the experimental group but worsened in controls at follow-up is clinically meaningful in contexts where ongoing contact with perpetrators (e.g., shared

parenting), economic pressures, and limited social support can perpetuate risk (Beck et al., 2014; Warshaw et al., 2013), and it is consistent with studies showing that acceptance and values work can increase psychological flexibility, self-efficacy, and coping in ways that translate into safer relational choices over time (Amir et al., 2019; Nasution & Yusuf, 2019; Baberi et al., 2022). Practically, these findings suggest that a brief, group-based CBT–ACT protocol can deliver culturally relevant skills that challenge cognitive distortions, reduce experiential avoidance, and scaffold values-consistent action, offering a feasible addition to community and shelter services in Türkiye where EA is common yet underrecognized (MoFSP, 2014). They also reinforce the promise of mindfulness-oriented, non-exposure pathways for survivors who may not be ready for trauma-focused processing but can benefit from skills that mitigate distress and support functional re-engagement (Banks et al., 2015; Pitt et al., 2020).

2.5.1. Limitations

Several limitations should be acknowledged when interpreting these findings. First, the modest sample size limited the statistical power for detecting between-group differences and conducting post-hoc contrasts, increasing the likelihood of Type II errors. With a larger cohort, some of the non-significant trends observed—particularly in emotional abuse and psychological well-being—might have reached statistical significance. Moreover, a small sample constrains the ability to explore subgroup effects, such as variations by age, marital status, or severity of abuse history, which could inform more targeted intervention strategies.

Second, the follow-up period was relatively short—only two weeks—which restricts the ability to draw firm conclusions about the durability of intervention effects.

While some gains were maintained during this period, it remains unclear whether these benefits would persist, diminish, or even strengthen over longer intervals. Emotional abuse recovery is a complex process that often unfolds over months or years. Without extended monitoring, the long-term impact of the CBT–ACT program cannot be fully evaluated.

Third, the study relied exclusively on self-report measures, introducing potential biases. Participants may have underreported perpetration behaviors or overreported positive change due to social desirability or perceived expectations from researchers. Self-reported emotion regulation and well-being are also subject to recall inaccuracies and may not fully capture moment-to-moment regulation processes. Including additional assessment methods—such as behavioral observations of conflict interactions, psychophysiological measures of stress reactivity, or collateral reports from significant others—would provide a more objective and multi-faceted evaluation of change.

Fourth, the absence of an active control group limits the ability to isolate the unique effects of the CBT–ACT integration from nonspecific therapeutic factors. While including a no-treatment control helps rule out the effects of time alone, factors such as group cohesion, mutual support, and therapist attention could have contributed to the observed improvements. Comparing the intervention to an active control (e.g., supportive counseling or psychoeducation) would help clarify whether the cognitive restructuring, mindfulness, and values-based components offer benefits above and beyond general therapeutic engagement.

Finally, the intervention was delivered in a single cultural context—Turkish women with a history of emotional abuse—limiting the generalizability of findings to other populations and settings. Cultural norms around emotional expression, gender roles, and

intimate relationships may shape both the EA experience and responsiveness to CBT–ACT strategies. Future research should examine the adaptability and efficacy of the program in diverse cultural, linguistic, and socio-economic contexts, as well as with mixed-gender groups or male survivors of IPV.

2.5.2. Clinical Implications

The present findings have several important clinical implications. First, integrating CBT and ACT strategies in a group format appears to address multiple recovery mechanisms simultaneously—cognitive restructuring of maladaptive beliefs, reduction of experiential avoidance, and promotion of values-consistent action—making it a versatile and comprehensive approach for survivors of emotional abuse. This dual focus may be especially valuable in contexts where EA is normalized and survivors may not initially recognize the abuse or its psychological impact. Second, the program's emphasis on emotion regulation skills, such as adaptive cognitive reframing and mindful acceptance, equips participants with practical tools to manage distress, which can reduce both vulnerability to re-victimization and the likelihood of engaging in perpetration behaviors. Third, the group delivery model can foster peer validation and reduce isolation, which are common barriers to recovery in IPV survivors. Finally, the program's relatively brief duration and structured manualization enhance its feasibility for implementation in community centers, shelters, and online platforms, increasing accessibility for women facing logistical or safety constraints. These results support the potential for broader dissemination of integrated CBT–ACT interventions in culturally tailored formats to strengthen resilience and promote sustainable recovery from emotional abuse.

2.5.3. Conclusion

In conclusion, Study 1 provides preliminary yet persuasive evidence that a culturally adapted CBT–ACT intervention improves cognitive emotion regulation and reduces perceived stress, with supportive indications of benefits for relational functioning and psychological well-being; the immediate gains, large effect sizes, and maintenance of improvements relative to control align with contemporary CBT and ACT literatures on trauma and IPV and point to a practical, survivor-centered pathway for strengthening resilience and reducing psychological risk in settings where EA is prevalent but often invisible (Beck, 2011; Seligman, 2011; Resick et al., 2012; Hayes, 2004; Luoma et al., 2007; Tirado-Muñoz et al., 2014; Banks et al., 2015; Follingstad & Rogers, 2014).

3. MAIN STUDY

3.1. Participants

The study included 60 married individuals between the ages of 18 and 64 years, all of whom were living with their spouses at the time of participation. Participants were randomly assigned to either an experimental group (n = 30) or a control group (n = 30). The overall age distribution was as follows: 31.7% were between 25 and 34 years, 31.7% between 35 and 44 years, 18.3% between 45 and 54 years, 16.7% between 18 and 24 years, and 1.7% between 55 and 64 years. Marital duration varied, with 30.0% of participants married for more than 10 years, 28.3% for 5–10 years, 23.3% for 2–5 years, 13.3% for 1–2 years, and 3.3% for 6 months to 1 year. In terms of educational attainment, 35.0% of participants held a bachelor’s degree, 35.0% had completed high school, 18.3% had attended vocational high school, 6.7% had completed middle school, 3.3% had a master’s degree, and 1.7% had completed only primary school. Regarding employment status,

41.7% identified as homemakers, 25.0% were employed full-time, 18.3% worked part-time, 6.7% were unemployed, and 5.0% were students. Family size also varied among participants: 28.3% had two children, 26.7% had three children, 18.3% had one child, 13.3% had no children, and 13.3% had four or more children.

Within the experimental group, the age distribution was 36.7% between 25 and 34 years, 26.7% between 35 and 44 years, 20.0% between 18 and 24 years, 13.3% between 45 and 55 years, and 13.3% between 56 and 64 years. Marital durations were reported as follows: 26.7% had been married for 2–5 years, 26.7% for 5–10 years, 23.3% for more than 10 years, 20.0% for 1–2 years, and 3.3% for 6 months to 1 year. Educational levels in this group included 30.0% with a high school diploma, 30.0% with a bachelor's degree, 23.3% with vocational high school, 6.7% with middle school, 6.7% with a master's degree, and 3.3% with primary school. In terms of employment, 36.7% were employed full-time, 33.3% were homemakers, 20.0% worked part-time, and 3.3% were unemployed. Family sizes included 33.3% with two children, 26.7% with three children, 23.3% with one child, 13.3% with no children, and 6.7% with four or more children.

In the control group, 36.7% of participants were aged 35–44 years, 26.7% were 25–34 years, 23.3% were 45–54 years, and 13.3% were 18–24 years. Marital duration was reported as follows: 36.7% had been married for more than 10 years, 30.0% for 5–10 years, 20.0% for 2–5 years, 6.7% for 1–2 years, and 3.3% for 6 months to 1 year. Educational attainment in this group included 40.0% with a bachelor's degree, 40.0% with a high school diploma, 13.3% with vocational high school, and 6.7% with middle school. Employment statuses were distributed as 50.0% homemakers, 16.7% part-time workers, 13.3% full-time workers, 10.0% students, and 10.0% unemployed. Family sizes included 26.7% with three

children, 23.3% with two children, 20.0% with four or more children, and 13.3% each with one or no children.

All participants reported that their spouses were employed full-time. Regarding spouses' educational attainment, 48.3% had completed high school, 41.7% held a bachelor's degree, 5.0% had completed primary school, 1.7% had completed middle school, 1.7% had attended vocational high school, and 1.7% had not completed high school.

3.2.Measures

3.2.1. Informed Consent Form

An informed consent form will be provided in order to outline the nature of the study, its purpose, procedures, potential risks, benefits, and any rights participants might have.

3.2.2. Demographic form

The demographic form will involve questions related to age group, gender, current relationship, status, duration of the relationship, sexual orientation, education level, employment status, number of children, the age of partner, the education of partner, the employment of partner, and whether they live together or not.

3.2.3. The Brief Symptom Inventory (BSI)

The scale developed by Derogatis in 1975, represents an important standardized screening instrument that enables one to quantitatively assess psychological distress and psychiatric disorders. It is a 53- self-report that measures nine dimensions that can be combined to represent three global indices: somatization, obsession–compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety and psychoticism.

The internal consistency coefficients for the questionnaire's initial administration varied from 0.71 to 0.85 (Adawi et al., 2019).

The short symptom inventory was adapted into Turkish by Şahin and Durak (1994). Cronbach Alpha internal consistency coefficients obtained from three separate studies of the scale are 0.96 and 0.95 and the coefficients obtained for the subscales vary between 0.55 and 0.86.

3.2.4. Multidimensional Measure of Emotional Abuse (MMEA)

The Multidimensional Measure of Emotional Abuse (MMEA) was developed by Murphy and Hoover in 1999 to assess emotional abuse in intimate partner relationships. The scale consists of 56 items that evaluate various forms of emotional violence through a Likert-type format. Participants are asked to indicate how frequently certain experiences occurred in the past six months, with response options ranging from 0 (never happened) to 6 (more than 20 times). If the experience did not occur in the last six months but has happened before, the response "7" is selected. The scale captures both perpetration (the actions of the abusive partner) and victimization (the experiences of the abused partner).

The Turkish adaptation of the MMEA, conducted by Demirtaş et al. (2018), demonstrated strong psychometric properties. The perpetration subscale showed a Cronbach's alpha of 0.89, and the victimization subscale had a Cronbach's alpha of 0.90, indicating excellent internal consistency. The scale is an effective tool for measuring emotional abuse across various forms, including control, humiliation, hostile withdrawal, and threats, within intimate relationships.

The internal consistency of the Multidimensional Measure of Emotional Abuse (MMEA) was assessed using Cronbach's alpha. Based on data from all participants (N = 60), the 56-item scale demonstrated excellent reliability, with a Cronbach's alpha coefficient of .97. This indicates that the scale items were highly consistent in measuring emotional abuse within the current sample. The internal consistency of the subscales was assessed using Cronbach's alpha. The analysis showed excellent reliability (α = .94) across the 8 items.

3.2.5. PERMA Measurement Tool

The PERMA Measurement Tool is a 23-item self-report scale developed by Butler and Kern (2015, 2016) to assess the five pillars of well-being outlined in Seligman's PERMA model: Positive Emotions, Engagement, Relationships, Meaning, and Accomplishment.

The scale uses a five-point Likert-type scale, and responses are averaged for each subscale. The internal consistency for the overall scale was found to be α = 0.94, with a test-retest stability of 0.78. In the Turkish context, the internal consistency reliability coefficient was 0.91, with subscale reliability coefficients ranging between 0.61 and 0.81. The test-retest correlation coefficient for the entire scale was 0.83, and for subscales, it ranged from 0.61 to 0.85. These findings demonstrate the scale's strong reliability and validity for assessing well-being in both general and clinical populations (Demirci et al., 2017).

The internal consistency of the PERMA Well-being Scale was assessed using Cronbach's alpha. The analysis, based on responses from 60 participants, showed excellent

reliability, with a Cronbach's alpha coefficient of .91 for the 23-item scale. This suggests that the PERMA items were highly consistent in capturing well-being dimensions in the current sample. The internal consistency of the PERMA subscale was acceptable, with a Cronbach's alpha of .77 across 8 items.

3.2.6. Cognitive Emotion Regulation Questionnaire (CERQ)

The Cognitive Emotion Regulation Questionnaire (CERQ) is 36-item scale developed by Garnefski et al. (2001), is designed to assess cognitive emotion regulation strategies used in response to negative life events. The scale measures nine different strategies (self-blame, acceptance, rumination, positive refocusing, refocusing, positive reappraisal, catastrophizing, blaming others, putting into perspective) that people use to cope with emotions following distressing situations. These strategies are categorized into adaptive and maladaptive strategies, reflecting how individuals cognitively manage their emotional responses:

The scale uses a five-point Likert scale to assess the frequency with which each strategy is employed, with scores ranging from 1 (almost never) to 5 (almost always). Each subscale is computed by summing the individual item scores, with scores for each strategy ranging from 4 to 20.

In the Turkish version of the Cognitive Emotion Regulation Questionnaire (CERQ), developed by Tuna and Bozo (2012), the psychometric properties were thoroughly examined. The internal consistency reliability of the subscales ranged from 0.72 for the self-blame subscale to 0.83 for the catastrophizing subscale, indicating good internal consistency across the measure. Additionally, the test-retest reliability of the subscales was

found to range between 0.50 for blaming others and 0.70 for self-blame, suggesting stable results over time. These findings affirm the reliability and validity of the Turkish version of the CERQ, making it an effective tool for assessing cognitive emotion regulation strategies.

The internal consistency of the Cognitive Emotion Regulation Questionnaire (CERQ) was assessed using Cronbach's alpha. Based on data from 60 participants, the 36-item version of the CERQ demonstrated high internal consistency, with a Cronbach's alpha coefficient of .87. This indicates that the scale items reliably measured cognitive emotion regulation strategies in this sample. The Cognitive Emotion Regulation Questionnaire (CERQ) subscale scores demonstrated acceptable internal consistency, with a Cronbach's alpha of .71 across the 9 items.

3.2.7. Perceived Stress Scale (PSS)

The scale was developed by Cohen et al. (1983) to measure the extent to which a person perceives his or her life as unpredictable, uncontrollable, or overloaded. It is a 14-item self-rating scale where individuals are asked to rate how often they have experienced certain emotions or thoughts in the last month, between 0 (not at all) and 5 (very often). The reported internal consistency of the scale indicated by Cronbach's alpha ranged from .71 to .91, while the test-retest reliability has been generally observed at $r > .70$ among different populationsç

The adaptation of the Perceived Stress Scale into Turkish was carried out by Yerlikaya and İnanç. In the study, the internal consistency coefficients were 0.84, 0.82 and

0.66 and test-retest reliability coefficients were calculated as 0.87, 0.88 and 0.72, respectively (Eskin et al., 2013).

The internal consistency of the Perceived Stress Scale (PSS) was examined using Cronbach's alpha. After reverse-coded items were properly recoded, the 14-item scale demonstrated excellent reliability, with a Cronbach's alpha coefficient of .93 (N = 60). This indicates that the scale reliably measures perceived stress in the current sample.

3.3. Procedure

Ethical approval for the study was obtained from Ankara Yıldırım Beyazıt University Ethics Committee (Decision No: 17-01-2024/01-282). Participants were recruited from a group connected to a local community center in Ankara. All potential participants were screened according to the study's inclusion and exclusion criteria. The inclusion criteria required participants to be: (1) women, (2) Turkish citizens, and (3) at least 18 years of age. The exclusion criteria involved screening for serious psychopathology using the Brief Symptom Inventory (BSI) and excluding individuals who self-identified as having an existing mental health condition. In line with standard recommendations for community-based samples, a BSI Global Severity Index (GSI) score above 1.00 was considered an indicator of severe psychological distress and used as the cut-off point for exclusion.

A total of 67 participants were initially recruited for the study. Following the provision of informed consent, all participants completed a demographic form and the Brief Symptom Inventory (BSI) to screen for psychological distress. Based on BSI scores, 7 participants were excluded for being outside the predetermined inclusion range. The

remaining participants were randomly assigned to either the experimental group or the control group using a computer-based randomization generator.

The experimental group attended a structured, nine-week intervention program integrating Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT) principles, developed specifically for this study and delivered at a community center located in Sincan, Ankara. To accommodate participants' schedules and maintain optimal group sizes, the intervention was conducted in three separate subgroups of approximately 10 participants each, meeting on Mondays, Wednesdays, or Fridays. All sessions lasted 90 minutes and followed a standardized weekly format (see Table 1). Attendance across all groups was full throughout the nine weeks. The same facilitator applied standardized procedures to all subgroups to ensure consistency, and no significant differences were observed between the three subgroups in any baseline or outcome measure.

During the first week, prior to the start of the intervention, all experimental group participants completed a battery of standardized self-report instruments under pre-test conditions. These included: (a) the Multidimensional Measure of Emotional Abuse (MMEA), assessing the frequency and nature of emotionally abusive behaviors experienced in intimate relationships (both perpetration and victimization); (b) the PERMA Measurement Tool, evaluating psychological well-being across five domains—Positive Emotion, Engagement, Relationships, Meaning, and Accomplishment; (c) the Cognitive Emotion Regulation Questionnaire (CERQ), measuring adaptive and maladaptive cognitive strategies used in response to stressful life events; and (d) the Perceived Stress Scale (PSS), assessing the degree to which participants appraised their lives as stressful

over the past month. All measures were administered in a quiet, private setting within the community center to ensure confidentiality and minimize distractions. The facilitator provided standardized instructions, clarified items without influencing responses, and ensured questionnaires were completed independently.

The same measures were administered at two additional time points: (1) immediately after the nine-week program (post-test), to assess short-term changes in emotional abuse, well-being, emotion regulation, and perceived stress; and (2) three weeks after post-test (follow-up), to evaluate the stability and retention of intervention effects, providing insight into short-term sustainability beyond the active treatment phase.

The control group was placed on a waitlist and did not receive any form of intervention during the study period. This waitlist-control design was chosen for ethical reasons—ensuring that all participants would eventually have access to the program—and methodological purposes, allowing for direct comparison between intervention and non-intervention groups within the same timeframe to isolate the effects of the program. However, after the study concluded, none of the control group participants opted to join the intervention, stating that a nine-week commitment was too time-consuming and incompatible with their personal schedules.

Intervention Content and Session Structure

Session 1 – Establishing Safety and Group Cohesion

The first session focused on creating a safe, supportive, and non-judgmental environment. Participants were welcomed and introduced to the programs's goals, structure, and expectations. Group norms were collaboratively established, including

confidentiality, respect, active listening, and constructive, non-judgmental communication. Icebreaker activities, such as "Common 10 Things" and "Speed Networking," fostered comfort, trust, and interpersonal connection. Participants discussed their personal goals for participation, followed by an introduction to the definition and common characteristics of emotional abuse (e.g., gaslighting, isolation, control) and its psychological effects. The session concluded with the assignment of reflective homework to encourage self-awareness between meetings.

Session 2 – Understanding Emotional Abuse and Cognitive-Behavioral Foundations

This session began with a review of the previous week and a discussion of homework reflections. Psychoeducation was provided on the psychological, emotional, and physiological impacts of emotional abuse, with particular attention to its influence on emotional regulation and stress responses. Core principles of CBT and ACT were introduced. Participants engaged in a mindfulness exercise, "Observing Thoughts as Clouds," to develop present-moment awareness. CBT techniques, including cognitive restructuring, were explained, demonstrated, and practiced, enabling participants to begin reframing maladaptive thoughts. Practical coping strategies were discussed, and participants were assigned to practice mindfulness exercises throughout the week.

Session 3 – Developing Mindfulness and Acceptance Skills

After a brief check-in and review, the facilitator introduced the role of emotional avoidance in trauma responses. Experiential exercises included mindful breathing, a body scan to enhance emotional awareness, and an acceptance-based guided visualization to acknowledge difficult emotions without judgment. A cognitive defusion exercise, "Leaves

on a Stream," was used to help participants create psychological distance from distressing thoughts. Group reflection discussions explored the impact of these practices on emotional self-regulation and self-awareness.

Session 4 – Values Clarification and Purpose Rebuilding

Participants engaged in structured reflective exercises to identify core values across multiple life domains (e.g., relationships, health, personal growth). They explored how emotional abuse may have disrupted their connection to these values and discussed the importance of reconnecting with personally meaningful goals. The facilitator guided participants in developing committed actions aligned with their values, while addressing internal barriers (e.g., fear, guilt, self-doubt) through ACT-based strategies such as defusion and mindfulness.

Session 5 – Deepening Cognitive Defusion Skills

This session expanded participants' understanding of cognitive defusion. Metaphors such as "Leaves on a Stream," "Passengers on a Bus," and "Thanking the Mind" were used to illustrate observing thoughts without attachment. Experiential exercises encouraged participants to label, repeat, and observe thoughts in a non-reactive manner. Emphasis was placed on altering the relationship to distressing thoughts rather than attempting to change their content. Group discussions facilitated reflection on the emotional and cognitive shifts achieved through these practices.

Session 6 – Behavioral Activation and Committed Action

The facilitator introduced behavioral activation as a strategy to counter avoidance and increase engagement in meaningful activities. Participants identified avoidance

patterns resulting from emotional abuse and explored their emotional consequences. SMART (Specific, Measurable, Achievable, Relevant, Time-bound) goals were developed in alignment with personal values. Behavioral experiments were designed to test maladaptive beliefs (e.g., “If I reach out, I’ll be rejected”). Group reflection highlighted how these experiments supported value-consistent action and emotional regulation.

Session 7 – Cultivating Self-Compassion

The focus of this session was on self-compassion as a central element of recovery. Participants examined self-critical thought patterns rooted in abuse and learned CBT-based strategies to reframe them. A guided loving-kindness meditation facilitated the development of emotional warmth and self-kindness. The group discussed how self-acceptance can reduce distress and foster resilience. Practical exercises encouraged the re-authoring of negative self-beliefs, and participants shared experiences of integrating self-compassion into daily routines.

Session 8 – Relapse Prevention and Maintenance Planning

Participants identified personal stress triggers, early warning signs of emotional dysregulation, and situations likely to challenge their coping skills. Individualized relapse prevention plans were developed, incorporating mindfulness, self-care, value-based behaviors, and support-seeking strategies. The facilitator emphasized the importance of consistency, adaptability, and self-compassion in sustaining progress. Reflection activities addressed anticipated challenges, including motivation, fear of setbacks, and reduced group support after program completion. Participants shared specific tools and routines they intended to maintain post-intervention.

Session 9 – Program Closure and Reflection

The final session provided space for participants to reflect on their progress, consolidate learning, and experience closure. A structured program evaluation was conducted through group discussion and anonymous feedback forms. Participants shared personal takeaways and composed letters of encouragement for fellow survivors. A gratitude practice and closing mindfulness exercise reinforced positive change and emotional closure. The session concluded with affirmations of individual strengths and encouragement to continue applying the skills learned.

Table 34. Procedural Guide: Session-by-Session Format

Session	**Title**	**Objectives**	**Main Techniques**
1	Introduction & Group Formation	Build trust, introduce goals, establish group cohesion	Icebreakers, group norms, expectations
2	Psychoeducation on Emotional Abuse	Increase awareness of abuse and stress reactions	Definitions, ACT/CBT intro, mindfulness
3	Mindfulness & Acceptance of Emotional Pain	Reduce avoidance, enhance regulation	Mindful breathing, body scan, acceptance
4	Values Clarification & Committed Action	Help participants identify and act in line with their values	Values reflection, goal setting
5	Cognitive Defusion	Reduce reactivity to negative thoughts	Metaphors, defusion exercises
6	Behavioral Activation & Committed Action	Break avoidance cycles, encourage value-aligned behavior	SMART goals, behavioral experiments

7	Self-Acceptance & Stress Reduction	Strengthen self-compassion and resilience	Loving-kindness, thought reframing
8	Relapse Prevention & Sustainability	Build long-term maintenance skills	Triggers worksheet, prevention planning
9	Program Closure & Integration	Review growth, celebrate achievements, plan future steps	Letters of support, group reflections

3.4.Results

Before proceeding with the main analyses, all raw scores obtained from the experimental and control groups were converted into Z-scores to assess whether the assumption of homogeneity was satisfied. Inspection of Z-scores indicated that both groups were homogeneous, with no values falling outside the ±3 range. This confirmed the absence of outliers that could bias the results. Consequently, all subsequent analyses were conducted using the original raw scores.

To determine whether significant differences existed between the experimental and control groups across all outcome measures, difference scores (i.e., post-test minus pre-test, and follow-up minus post-test) were computed within each group. This approach allowed for clearer change evaluation, minimizing the potential confounding effects of individual baseline differences. Given the approximately two-month interval between pre-test and post-test, difference scores were also used to help control for potential external or environmental influences that could have occurred during this time.

The following statistical procedures were used for hypothesis testing, for examining pre- to post-intervention changes within each group (experimental and control) across multiple dependent variables (e.g., emotion regulation, well-being, and emotional abuse), one-way multivariate analyses of variance (MANOVA) were conducted. This allowed for simultaneous evaluation of differences across multiple outcome dimensions while controlling for Type I error inflation. For comparing post-test scores between the experimental and control groups, independent samples t-tests were used on the difference scores, evaluating whether the degree of change differed significantly between groups. For examining within-group changes from post-test to follow-up, paired samples t-tests were used separately for the experimental and control groups. This allowed for the assessment of the durability of the intervention's effects over time.

For the variable of perceived stress, a different approach was applied due to the unidimensional nature of the measure. Specifically, a one-way ANOVA was used to assess pre- and post-intervention differences in perceived stress for the experimental and control groups separately. Independent samples t-tests were then conducted on the difference scores to compare the extent of stress reduction between the two groups. Paired samples t-tests were also conducted to compare post-test and follow-up stress levels within each group.

These statistical methods allowed for a rigorous, multi-layered analysis of change over time, intervention effects, and group comparisons across the study's key psychological outcomes: perceived stress, psychological well-being, emotion regulation, and emotional abuse.

3.4.1. Cognitive Emotion Regulation Scale

Pre Experimental – Post Experimental Comparisons

A one-way multivariate analysis of variance (MANOVA) was conducted to examine the effect of the intervention (pre- vs. post-experimental group) on the combined cognitive emotion regulation strategies. The results revealed a statistically significant multivariate effect of group, *Pillai's Trace* = .943, $F(9, 50) = 92.06$, $p < .001$, partial $\eta^2 = .943$. This indicates that the intervention had a large and statistically significant impact on the combined set of dependent variables. Similar findings were confirmed across other multivariate statistics, including *Wilks' Lambda* = .057, *Hotelling's Trace* = 16.57, and *Roy's Largest Root* = 16.57, all with $p < .001$ and partial $\eta^2 = .943$.

Table 35. Multivariate Tests for Group Effect on Emotion Regulation Strategies

Effect	Test Statistic	Value	F	Hypothesis df	Error df	*p*	Partial η^2
Intercept	Pillai's Trace	.998	2387.15	9	50	< .001	.99
	Wilks' Lambda	.002	2387.15	9	50	< .001	.99
	Hotelling's Trace	429.69	2387.15	9	50	< .001	.99
	Roy's Largest Root	429.69	2387.15	9	50	< .001	.99

Group	Pillai's Trace	.943	92.06	9	50	< .001	.94
	Wilks' Lambda	.057	92.06	9	50	< .001	.93
	Hotelling's Trace	16.57	92.06	9	50	< .001	.93
	Roy's Largest Root	16.57	92.06	9	50	< .001	.93

Note. Design: Intercept + GROUP. All *F*-values are exact statistics.

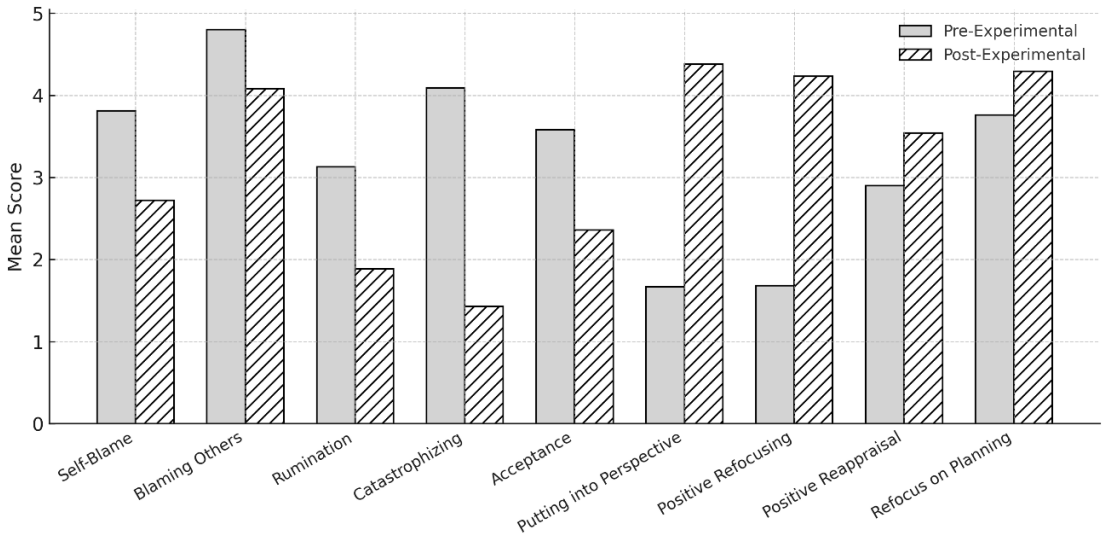
Descriptive statistics indicated that participants in the post-experimental group had lower mean scores on maladaptive strategies such as self-blame (M = 2.72, SD = 0.48), blaming others (M = 4.08, SD = 0.44), rumination (M = 1.89, SD = 0.58), catastrophizing (M = 1.43, SD = 0.40), and acceptance (M = 2.36, SD = 0.65), compared to the pre-experimental group (Ms = 3.81, 4.80, 3.13, 4.09, and 3.58, respectively).

Conversely, the post-experimental group demonstrated higher scores on adaptive strategies such as putting into perspective (M = 4.38, SD = 0.52), positive refocusing (M = 4.23, SD = 0.70), positive reappraisal (M = 3.54, SD = 0.77), and refocus on planning (M=4.42, SD = 0.35), compared to the pre-experimental group (Ms = 1.67, 1.68, 2.90, and 3.76, respectively).

Table 36. Descriptive Statistics for Cognitive Emotion Regulation Questionnaire (CERQ) Experimental Subscales

Subscale	Pre-Experimental Mean (SD)	Post-Experimental Mean (SD)
Self-Blame	3.81 (.56)	2.72 (.48)
Blaming Others	4.80 (.26)	4.08 (.44)
Rumination	3.13 (1.03)	1.89 (.58)
Catastrophizing	4.09 (.70)	1.43 (.40)
Acceptance	3.58 (.70)	2.36 (.65)
Putting into Perspective	1.67 (.51)	4.38 (.52)
Positive Refocusing	1.68 (.57)	4.23 (.70)
Positive Reappraisal	2.90 (.74)	3.54 (.77)
Refocus on Planning	3.76 (.64)	4.42 (.35)

Figure 16. Pre- and Post-Intervention Comparison of CERQ Subscale Mean Scores in the Experimental Group



These results suggest a significant shift in participants' emotion regulation strategies following the intervention, with increased use of adaptive strategies and decreased use of maladaptive strategies.

Pre-Control – Post-Control Comparisons

A one-way multivariate analysis of variance (MANOVA) was performed to examine whether there were significant changes in cognitive emotion regulation strategies in the control group over time (pre- and post-assessment). The analysis revealed no statistically significant multivariate effect of time, *Pillai's Trace* = .205, $F(9, 50) = 1.43$, $p = .200$, partial $\eta^2 = .205$. This suggests that, unlike the experimental group, the control group did not exhibit significant changes across the nine subscales of the Cognitive Emotion Regulation Questionnaire (CERQ).

Table 37. Multivariate Tests for Group Effect on Emotion Regulation Strategies – Control Group

Effect	Test Statistic	Value	F	Hypothesis df	Error df	*p*	Partial η^2
Intercept	Pillai's Trace	.989	513.27	9	50	< .001	.989
	Wilks' Lambda	.011	513.27	9	50	< .001	.989
	Hotelling's Trace	92.389	513.27	9	50	< .001	.989
	Roy's Largest Root	92.389	513.27	9	50	< .001	.989
Group	Pillai's Trace	.205	1.43	9	50	.200	.205
	Wilks' Lambda	.795	1.43	9	50	.200	.205
	Hotelling's Trace	.258	1.43	9	50	.200	.205
	Roy's Largest Root	.258	1.43	9	50	.200	.205

Note. Design: Intercept + GROUP. All *F*-values are exact statistics.

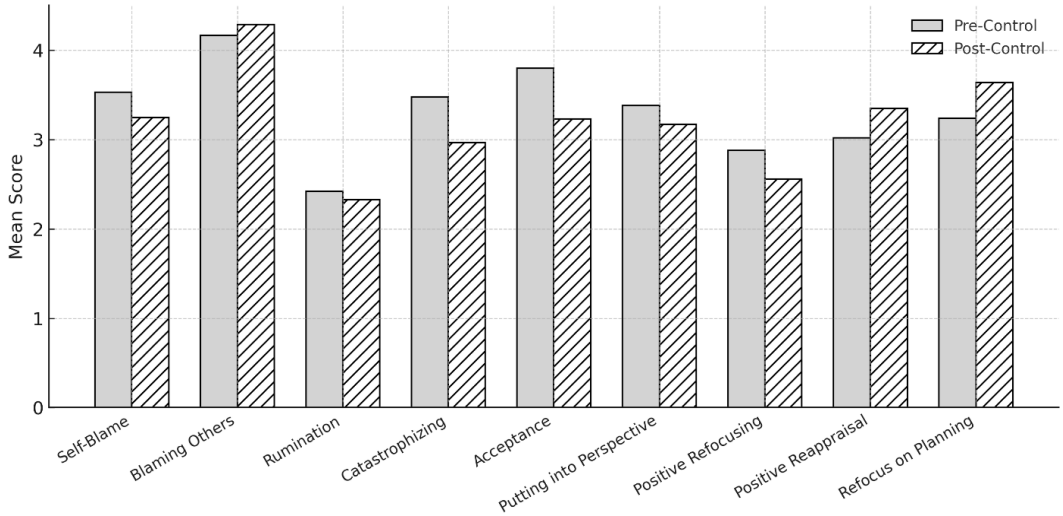
Descriptive statistics for the control group showed minor variations between the pre- and post-assessment scores across subscales. For example, self-blame decreased slightly from a mean of 3.53 (SD = .93) to 3.25 (SD = .86), and catastrophizing dropped from 3.48 (SD = 1.00) to 2.97 (SD = 1.15). Conversely, blaming others increased marginally from 4.18 (SD = .80) to 4.29 (SD = .57), and refocus on planning increased from 3.24 (SD = 1.06) to 3.64 (SD = 1.15). However, none of these changes have reached statistical significance.

Table 38. Descriptive Statistics for Cognitive Emotion Regulation Questionnaire (CERQ) Control Subscales

Subscale	Pre-Control M (SD)	Post-Control M (SD)
Self-Blame	3.53 (.93)	3.25 (.86)
Blaming Others	4.18 (.80)	4.29 (.57)
Rumination	2.42 (.89)	2.33 (.80)
Catastrophizing	3.48 (1.00)	2.97 (1.15)
Acceptance	3.80 (.96)	3.23 (1.38)
Putting into Perspective	3.38 (.83)	3.17 (.99)
Positive Refocusing	2.88 (1.01)	2.56 (.99)
Positive Reappraisal	3.03 (.96)	3.35 (1.09)
Refocus on Planning	3.24 (1.06)	3.64 (1.15)

Note. M = mean; SD = standard deviation.

Figure 17. Pre- and Post-Test Comparison of CERQ Subscale Mean Scores in the Control Group



Post Experimental – Post Control Comparisons

An independent samples t-test was conducted to compare the mean change scores (post-test minus pre-test) of cognitive emotion regulation strategies between the experimental and control groups. There was a significant difference in scores between the experimental group (M = -1.35, SD = 0.56) and the control group (M = -0.13, SD = 0.62); $t(58) = -8.08$, $p < .001$, 95% CI [-1.53, -0.92]. These results suggest that participants in the experimental group showed significantly greater improvement in their overall cognitive emotion regulation strategies compared to those in the control group.

Table 39. Independent Samples t-Test Comparing Mean Change Scores on the CERQ Between Experimental and Control Groups

Group	***n***	**Mean**	**SD**	**SEM**
Experimental	30	1.35	0.56	0.10
Control	30	0.13	0.62	0.11

t(df)	**p**	**Mean Diff**	**SEM Diff**	**95% CI Lower**
8.08 (58)	< .001	1.23	0.15	1.53

Note. Mean values represent post-pre difference scores on the Cognitive Emotion Regulation Questionnaire (CERQ). SD = Standard Deviation; SEM = Standard Error of the Mean; CI = Confidence Interval.

Follow-up Comparison

To examine whether there were significant changes in scores from post-test to follow-up within each group, two paired samples t-tests were conducted.

Experimental Group (Post vs. Follow-Up)

There was a statistically significant increase in scores from post-test (M = 2.57, SD = 0.38) to follow-up (M = 3.18, SD = 0.39) in the experimental group, $t(29) = -7.02$, $p < .001$, 95% CI [–0.78, –0.43], $d = -1.28$. The mean difference was –0.60 (SD = 0.47), indicating a large and statistically significant improvement, which suggests that the intervention had a strong positive effect over time.

Control Group (Post vs. Follow-Up)

The control group also showed a statistically significant change in scores from post-test (M = 3.20, SD = 0.41) to follow-up (M = 2.86, SD = 0.47), $t(29) = 3.15$, $p = .004$, 95% CI [0.12, 0.56], $d = 0.58$. The mean difference was 0.34 (SD = 0.59), indicating a moderate decrease in scores, which may suggest a decline in the measured construct over time in the absence of intervention.

The results show opposing trends between groups. The experimental group experienced a large and significant increase in scores, while the control group experienced a moderate but significant decrease. This divergence strongly suggests that the intervention had a substantial and beneficial impact, helping to improve outcomes in the experimental group, while the control group declined in the same period.

Table 40. Descriptive Statistics for Post-Test and Follow-Up Scores

Group	Time Point	N	M	SD	SE

Experimental	Post-Test	30	2.57	0.38	0.07
Experimental	Follow-Up	30	3.18	0.39	0.07
Control	Post-Test	30	3.20	0.41	0.08
Control	Follow-Up	30	2.86	0.47	0.09

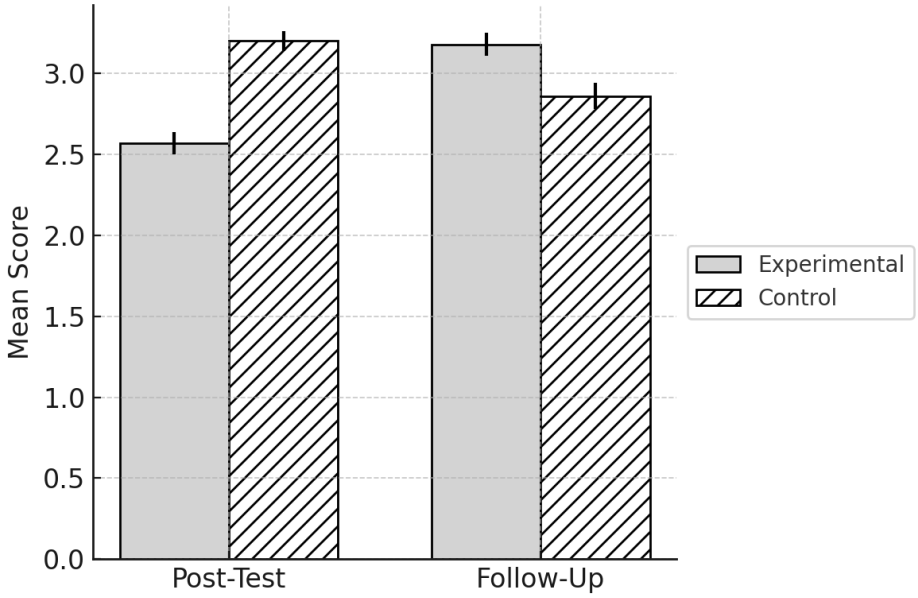
Note. M = Mean; SD = Standard Deviation; SE = Standard Error.

Table 41. Paired Samples t-Test Results

Group	t	df	p	M Diffe	SD Diff	SE Diff	95% CI [LL,UL]		Cohen's d
Experimental	–7.02	29	< .001	–0.60	0.47	0.09	–0.78	–0.43	–1.28
Control	3.15	29	.004	0.34	0.59	0.11	0.12	0.56	0.58

Note. CI = Confidence Interval. Cohen's d calculated using the standard deviation of differences.

Figure 18. Post-Test and Follow-Up Scores by Group



3.4.2. Multidimensional Measure of Emotional Abuse

Pre Experimental – Post Experimental Comparisons

A one-way multivariate analysis of variance (MANOVA) was conducted to examine the effect of the intervention (group: experimental vs. control) on the combined subscales of the Multidimensional Measure of Emotional Abuse (MMEA). The results revealed a statistically significant multivariate effect of group, Pillai's Trace = .894, $F(8, 51) = 53.50$, $p < .001$, partial $\eta^2 = .894$. Similar results were obtained across other multivariate statistics, including Wilks' Lambda = .106, Hotelling's Trace = 8.39, and Roy's Largest Root = 8.39, all indicating statistically significant differences with $p < .001$ and large effect sizes (partial $\eta^2 = .894$). These findings suggest that the intervention had a strong and statistically significant effect on the overall emotional abuse experiences as measured across the MMEA subscales.

Table 42. Multivariate Test Results for Group Differences on the Multidimensional Measure of Emotional Abuse (MMEA)

Effect	Test Statistic	Value	F	Hypothesis df	Error df	*p*	Partial η^2
Intercept	Pillai's Trace	.989	552.56	8	51	< .001	.989
	Wilks' Lambda	.011	552.56	8	51	< .001	.989
	Hotelling's Trace	86.68	552.56	8	51	< .001	.989
	Roy's Largest Root	86.68	552.56	8	51	< .001	.989
Group	Pillai's Trace	.894	53.50	8	51	< .001	.894
	Wilks' Lambda	.106	53.50	8	51	< .001	.894
	Hotelling's Trace	8.39	53.50	8	51	< .001	.894
	Roy's Largest Root	8.39	53.50	8	51	< .001	.894

Note. Dependent variables are the subscales of the MMEA. Design: Intercept + GROUP. All *F*-values are exact statistics.

Descriptive statistics were calculated for the eight subscales of the Multidimensional Measure of Emotional Abuse (MMEA) in both the pre- and post-experimental groups. Across all subscales, mean scores were lower in the post-experimental group compared to the pre-experimental group, indicating a reduction in both emotional abuse perpetration and victimization following the intervention.

In the perpetration subscales, participants in the pre-experimental group reported higher scores compared to the post-experimental group. Specifically, the mean score for Perpetration–Restrictive Engulfment decreased from 4.29 (SD = 0.93) to 2.34 (SD = 0.36), Perpetration–Denigration dropped from 3.82 (SD = 0.97) to 1.42 (SD = 0.30),

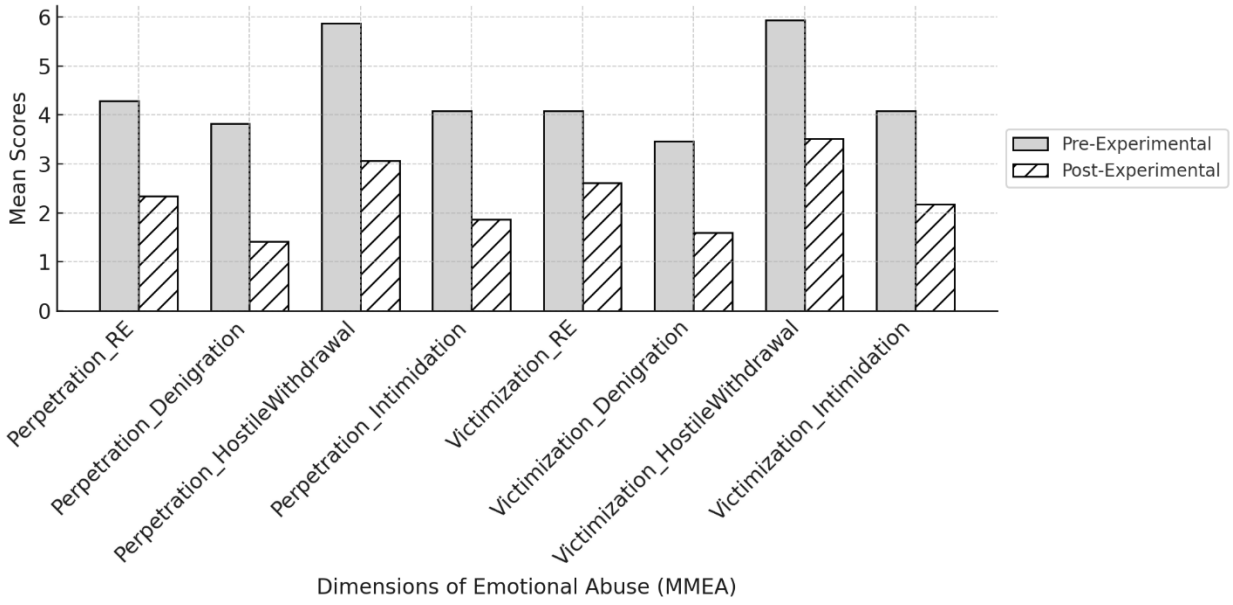
Perpetration–Hostile Withdrawal declined from 5.88 (SD = 0.78) to 3.07 (SD = 0.38), and Perpetration–Intimidation decreased from 4.10 (SD = 0.75) to 1.87 (SD = 0.31). Similarly, the victimization subscales showed a reduction in post-experimental scores. The mean score for Victimization–Restrictive Engulfment decreased from 4.08 (SD = 0.68) to 2.61 (SD = 0.52), Victimization–Denigration decreased from 3.46 (SD = 0.99) to 1.59 (SD = 0.41), Victimization–Hostile Withdrawal declined from 5.94 (SD = 0.74) to 3.52 (SD = 0.42), and Victimization–Intimidation dropped from 4.08 (SD = 0.90) to 2.17 (SD = 0.34). Overall, these descriptive patterns suggest that the intervention was associated with lower reported levels of both emotional abuse perpetration and victimization across all measured dimensions.

Table 43. Descriptive Statistics for Pre-Experimental and Post-Experimental Groups on Emotional Abuse Dimensions

Dimension	**Pre-Experimental M (SD)**	**Post-Experimental M (SD)**
Perpetration - Restrictive Engulfment	4.29 (0.93)	2.34 (0.36)
Perpetration - Denigration	3.82 (0.97)	1.42 (0.30)
Perpetration - Hostile Withdrawal	5.88 (0.78)	3.07 (0.38)
Perpetration - Intimidation	4.10 (0.75)	1.87 (0.30)
Victimization - Restrictive Engulfment	4.08 (0.68)	2.61 (0.52)
Victimization - Denigration	3.46 (0.99)	1.59 (0.41)

Victimization - Hostile Withdrawal	5.94 (0.74)	3.52 (0.41)
Victimization - Intimidation	4.08 (0.90)	2.17 (0.34)

Figure 19. Mean Scores on MMEA Subscales for Pre- and Post-Experimental Groups



Pre-Control – Post-Control Comparisons

A one-way multivariate analysis of variance (MANOVA) was conducted to assess whether there were statistically significant changes in emotional abuse patterns within the control group across the eight subscales of the Multidimensional Measure of Emotional Abuse (MMEA). The analysis revealed no statistically significant multivariate effect of time (pre- vs. post-control), *Pillai's Trace* = .141, $F(8, 51) = 1.05$, $p = .414$, partial $\eta^2 = .141$. This result was consistent across all multivariate test statistics, including *Wilks' Lambda* = .859, *Hotelling's Trace* = .164, and *Roy's Largest Root* = .164, all indicating non-significant differences (all $p = .414$).

Table 44. Multivariate Test Results for Group Differences on the MMEA – Control Group

Effect	Test Statistic	Value	F	Hypothesis df	Error df	*p*	Partial η^2
Intercept	Pillai's Trace	.937	94.86	8	51	< .001	.937
	Wilks' Lambda	.063	94.86	8	51	< .001	.937
	Hotelling's Trace	14.88	94.86	8	51	< .001	.937
	Roy's Largest Root	14.88	94.86	8	51	< .001	.937
Group	Pillai's Trace	.141	1.05	8	51	.414	.141
	Wilks' Lambda	.859	1.05	8	51	.414	.141
	Hotelling's Trace	.164	1.05	8	51	.414	.141
	Roy's Largest Root	.164	1.05	8	51	.414	.141

Note. Design: Intercept + GROUP. All *F*-values are exact statistics.

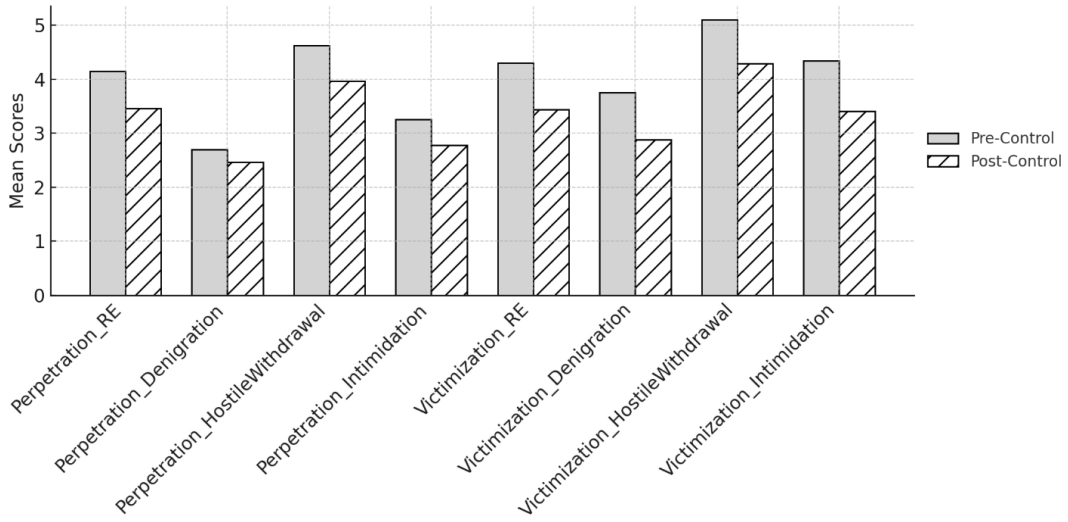
Descriptive statistics support these findings. While there were slight reductions in mean scores from pre- to post-test across most MMEA subscales in the control group, these changes were relatively modest and statistically non-significant. For example, *Perpetration–Restrictive Engulfment* decreased from *M* = 4.15 (SD = 1.75) to *M* = 3.46 (SD = 1.52), and *Victimization–Restrictive Engulfment* declined from *M* = 4.30 (SD = 1.84) to *M* = 3.44 (SD = 1.61). Other subscales, such as Perpetration–Hostile Withdrawal (from M = 4.62 to M = 3.97) and Victimization–Hostile Withdrawal (from M = 5.10 to M = 4.29),

showed similar non-significant trends. These results indicate that, without the intervention, participants in the control group did not exhibit significant changes in their emotional abuse experiences over time.

Table 45. Descriptive Statistics for Pre-Control and Post-Control Groups on Emotional Abuse Dimensions

Dimension	Pre-Control M (SD)	Post-Control M (SD)
Perpetration - Restrictive Engulfment	4.15 (1.75)	3.46 (1.52)
Perpetration - Denigration	2.70 (1.47)	2.46 (1.96)
Perpetration - Hostile Withdrawal	4.62 (1.38)	3.97 (1.26)
Perpetration - Intimidation	3.25 (1.36)	2.78 (1.05)
Victimization - Restrictive Engulfment	4.30 (1.84)	3.44 (1.61)
Victimization - Denigration	3.75 (2.24)	2.88 (1.73)
Victimization - Hostile Withdrawal	5.10 (1.43)	4.29 (1.40)
Victimization - Intimidation	4.34 (1.94)	3.41 (1.61)

Figure 20. Mean Scores on MMEA Subscales for Pre- and Post-Control Groups



Post Experimental – Post Control Comparisons

An independent samples t-test was conducted to compare the mean change scores in emotional abuse (MMEA) between the experimental and control groups. The results indicated a statistically significant difference, $t(58) = -3.73$, $p < .001$, 95% CI [-2.21, -0.67]. Participants in the experimental group ($M = -2.13$, $SD = 0.68$) reported significantly greater reductions in emotional abuse compared to those in the control group ($M = -0.69$, $SD = 2.00$). The mean difference between groups was -1.44 ($SE = 0.39$), demonstrating the effectiveness of the intervention in reducing emotional abuse.

Table 46. Group Statistics and Independent Samples t-Test Results for MMEA Change Scores

Group	N	M	SD	SE
Experimental	30	2.13	0.67847	0.12387
Control	30	0.69	2.00273	0.36565

Note. M = mean; SD = standard deviation.

t	df	p	Mean Difference	Standard Error Difference	95% CI Lower	95% CI Upper
3.73	58	< .001	1.44	0.39	2.21	-0.67

Note. Mean values represent post-pre difference scores on the Cognitive Emotion Regulation Questionnaire (CERQ). SD = Standard Deviation; SEM = Standard Error of the Mean; CI = Confidence Interval.

Follow-Up Comparisons

To evaluate changes in scores from post-test to follow-up, paired samples t-tests were conducted separately for the experimental and control groups.

Experimental Group (Post vs. Follow-Up)

There was no statistically significant difference between post-test scores (M = 2.32, SD = 0.23) and follow-up scores (M = 2.54, SD = 0.71) in the experimental group, $t(29) = –1.76$, $p = .089$, 95% CI [–0.46, 0.03], $d = –0.32$.

The mean increase of 0.21 points suggests a positive trend, but it did not reach statistical significance, indicating that the effect of the intervention was not conclusive in this case.

Control Group (Post vs. Follow-Up)

In contrast, the control group showed a statistically significant decrease in scores from post-test (M = 3.34, SD = 1.24) to follow-up (M = 2.32, SD = 0.23), $t(29) = 4.36$, $p < .001$, 95% CI [0.54, 1.49], $d = 0.79$. The mean difference of 1.01 points indicates a large and significant decline over time in the absence of intervention.

The results suggest that the experimental group showed a non-significant upward trend, while the control group experienced a large and significant decrease in scores. This contrast may imply that the intervention in the experimental group helped to maintain or improve scores, whereas the absence of intervention in the control group led to a deterioration in the measured construct.

Table 47. Descriptive Statistics for Post-Test and Follow-Up Scores

Group	Time Point	N	M	SD	SE
Experimental	Post-Test	30	2.32	0.23	0.04
Experimental	Follow-Up	30	2.54	0.71	0.13
Control	Post-Test	30	3.34	1.24	0.23
Control	Follow-Up	30	2.32	0.23	0.04

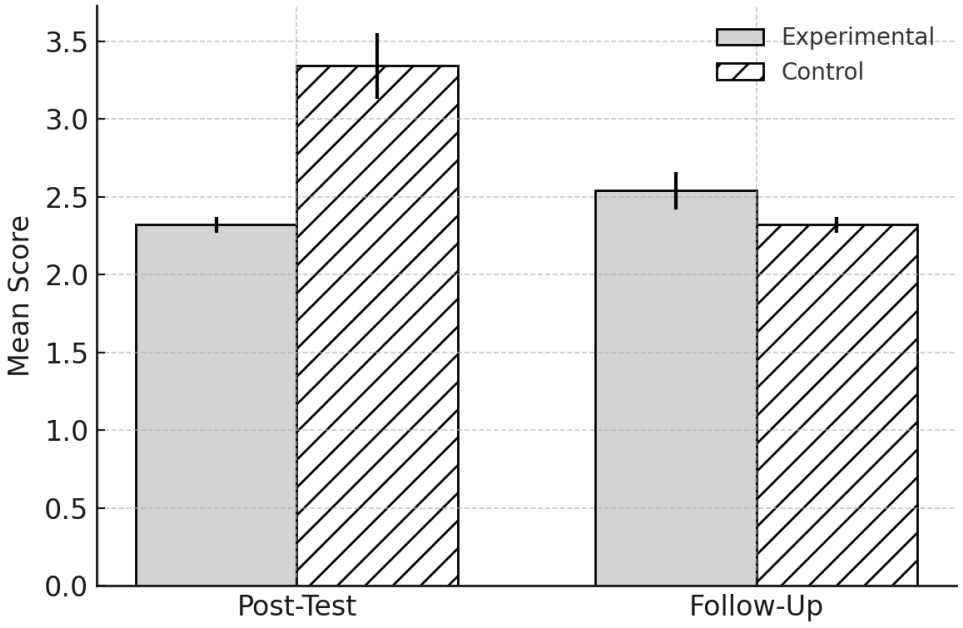
Note. M = Mean; SD = Standard Deviation; SE = Standard Error.

Table 48. Paired Samples t-Test Results

Group	t	df	p	M Diff	SD Diff	SE Diff	95% CI [LL,UL]		Cohen's d
Experimental	–1.76	29	.089	–0.21	0.66	0.12	–0.46	0.03	–0.32
Control	4.36	29	< .001	1.01	1.27	0.23	0.54	1.49	0.79

Note. CI = Confidence Interval. Cohen's d calculated using the standard deviation of differences.

Figure 21. Post-Test and Follow-Up Scores by Group



1.1.1. PERMA Measure

Pre Experimental – Post Experimental Comparisons

A one-way multivariate analysis of variance (MANOVA) was conducted to examine the effect of group (experimental vs. control) on the post-intervention scores of the PERMA subscales, including Positive Emotion, Engagement, Relationships, Meaning, Accomplishment, Health, Negative Emotion, and Loneliness. The results revealed a statistically significant multivariate effect of group, Pillai's Trace = .810, $F(8, 51) = 27.10$, $p < .001$, partial $\eta^2 = .810$, indicating a large effect size. Similar results were found using Wilks' Lambda, Hotelling's Trace, and Roy's Largest Root (all $p < .001$), confirming the robustness of the group effect across the PERMA dimensions.

Table 49. Multivariate Test Results for Group Differences Across PERMA Subscales

Effect	Test	Value	F	Hypothesis df	Error df	p	Partial η^2

Intercept	Pillai's Trace	.996	1506.52[b]	8	51	< .001	.996
	Wilks' Lambda	.004	1506.52[b]	8	51	< .001	.996
	Hotelling's Trace	236.32	1506.52[b]	8	51	< .001	.996
	Roy's Largest Root	236.32	1506.52[b]	8	51	< .001	.996
Group	Pillai's Trace	.810	27.10[b]	8	51	< .001	.810
	Wilks' Lambda	.190	27.10[b]	8	51	< .001	.810
	Hotelling's Trace	4.25	27.10[b]	8	51	< .001	.810
	Roy's Largest Root	4.25	27.10[b]	8	51	< .001	.810

Note. Design = Intercept + Group. [b] = Exact statistic. *p* values less than .001 are reported as < .001 in accordance with APA 7 guidelines.

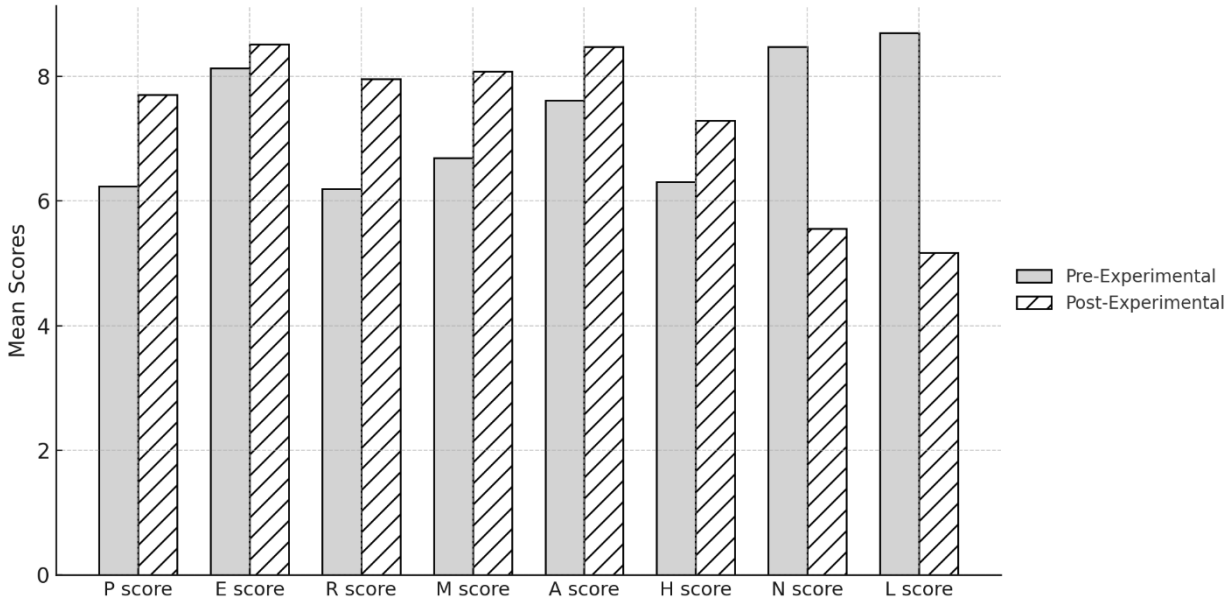
Descriptive statistics indicated that the experimental group showed improvements across most domains from pre- to post-test. For example, scores for Positive Emotion increased from $M = 6.24$, $SD = 0.72$ (pre) to $M = 7.11$, $SD = 0.82$ (post); Engagement increased from $M = 8.13$, $SD = 1.15$ to $M = 8.52$, $SD = 0.84$; and Relationships increased from $M = 6.20$, $SD = 1.33$ to $M = 7.96$, $SD = 0.86$. Notably, scores on Negative Emotion and Loneliness, where lower scores indicate of better well-being, decreased in the experimental group. Negative Emotion dropped from $M = 8.48$, $SD = 0.95$ to $M = 5.56$, $SD = 1.07$; Loneliness decreased from $M = 8.70$, $SD = 1.70$ to $M = 5.17$, $SD = 1.09$.

Table 50. Descriptive Statistics for Pre-Experimental and Post-Experimental Group on PERMA Measure

Dimension	Pre-Experimental M (SD)	Post-Experimental M (SD)
P_score	6.24 (0.72)	7.71 (0.82)
E_score	8.13 (1.15)	8.52 (0.84)
R_score	6.20 (1.33)	7.96 (0.86)
M_score	6.69 (0.93)	8.08 (0.62)
A_score	7.61 (1.15)	8.48 (0.82)
H_score	6.31 (1.01)	7.29 (0.75)
N_score	8.48 (0.95)	5.56 (1.07)
L_score	8.70 (1.70)	5.17 (1.08)

Note. M = Mean; SD = Standard Deviation.

Figure 21. Comparison of Pre- and Post-Intervention Scores on PERMA Dimensions in the Experimental Group



These results suggest that the intervention based on CBT and ACT had a statistically significant and meaningful impact on participants' psychological well-being across multiple PERMA domains.

Pre-Control – Post-Control Comparisons

A one-way multivariate analysis of variance (MANOVA) was conducted to examine whether there were significant changes in well-being outcomes across the PERMA dimensions (Positive Emotion, Engagement, Relationships, Meaning, Accomplishment, Health, Negative Emotion, and Loneliness) between pre- and post-test periods in the control group. The multivariate test revealed that the effect of time (pre-test vs. post-test) was not statistically significant, Pillai's Trace = .076, $F(8, 51) = 0.53$, $p = .831$, partial $\eta^2 = .076$, indicating a small and non-significant effect. Similar results were obtained for Wilks' Lambda, Hotelling's Trace, and Roy's Largest Root (all $p > .05$).

Table 51. Multivariate Test Results for Group Differences in PERMA Scores (Control Group)

Effect	Test	Value	F	Hypothesis df	Error df	p	Partial η^2
Intercept	Pillai's Trace	.993	968.92[b]	8	51	<.001	.993
	Wilks' Lambda	.007	968.92[b]	8	51	<.001	.993
	Hotelling's Trace	151.99	968.92[b]	8	51	<.001	.993
	Roy's Largest Root	151.99	968.92[b]	8	51	<.001	.993
Group	Pillai's Trace	.076	0.53[b]	8	51	.831	.076
	Wilks' Lambda	.924	0.53[b]	8	51	.831	.076
	Hotelling's Trace	.083	0.53[b]	8	51	.831	.076
	Roy's Largest Root	.083	0.53[b]	8	51	.831	.076

Note. Design = Intercept + Group. [b] = Exact statistic. *p* values < .001 are written as "< .001" in accordance with APA 7 reporting guidelines.

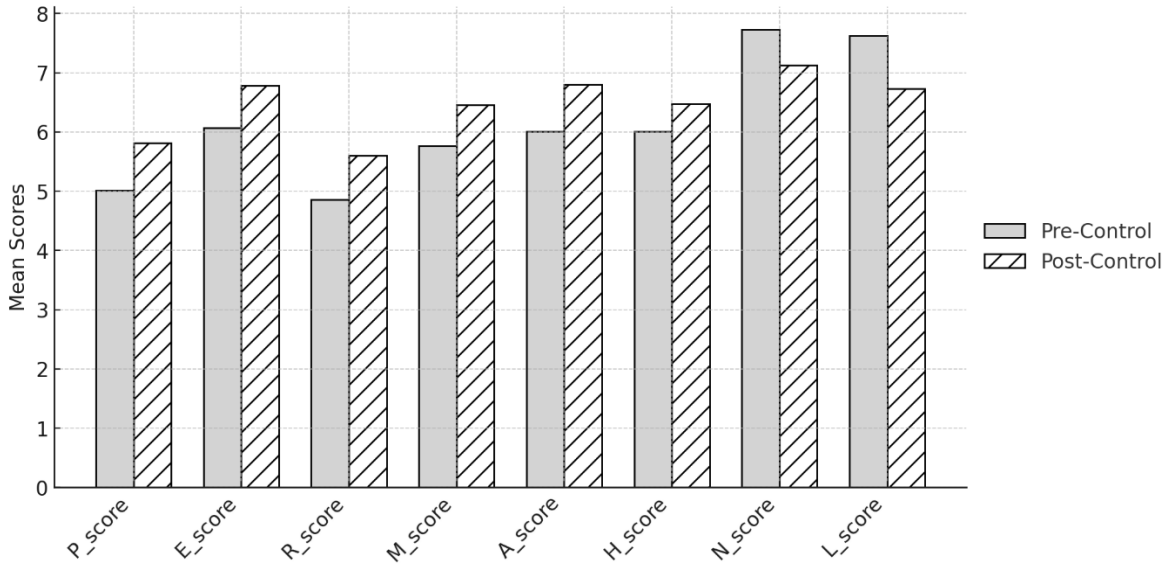
Descriptive statistics showed only minor and inconsistent differences between pre- and post-test scores in the control group. For instance, Positive Emotion increased from *M* = 5.01, *SD* = 1.42 to *M* = 5.82, *SD* = 1.95, while Engagement increased slightly from *M* = 6.07, *SD* = 1.73 to *M* = 6.78, *SD* = 2.06. However, Relationships showed minimal change, from *M* = 4.86, *SD* = 1.65 to *M* = 5.00, *SD* = 1.96. Negative outcomes, such as Negative Emotion, decreased slightly from M = 7.73, SD = 1.09, to M = 7.13, SD = 1.46, while Loneliness decreased from M = 7.63, SD = 1.90, to *M* = 6.73, *SD* = 2.55. However, none of these differences reached statistical significance.

Table 52. Descriptive Statistics for Pre-Control and Post-Control Group on PERMA Measures

Dimension	Pre-Control M (SD)	Post-Control M (SD)
P_score	5.01 (1.42)	5.82 (1.95)
E_score	6.07 (1.73)	6.78 (2.06)
R_score	4.86 (1.65)	5.60 (1.96)
M_score	5.76 (1.36)	6.46 (1.64)
A_score	6.01 (1.73)	6.80 (2.09)
H_score	6.01 (1.42)	6.48 (1.51)
N_score	7.73 (1.09)	7.13 (1.46)
L_score	7.63 (1.90)	6.73 (2.55)

Note. SD=standart deviation

Figure 22. Pre- and Post-Test Scores on PERMA and Well-Being Dimensions in the Control Group



These findings suggest that the control group did not experience significant changes in well-being indicators over the study period, consistent with expectations for a non-intervention condition.

Post Experimental – Post Control Comparisons

An independent samples t-test was conducted to compare the change in psychological well-being scores between the experimental and control groups. The results indicated that there was no statistically significant difference in the well-being difference scores between the experimental group ($M = 0.42$, $SD = 0.84$) and the control group ($M = 0.46$, $SD = 1.71$), $\mathbf{t}(58) = -0.11$, $p = .914$, two-tailed. The 95% confidence interval for the mean difference ranged from –0.732 to 0.657.

Table 53. Group Statistics and Independent Samples t-Test Comparing Well-Being Difference Scores Between Experimental and Control Groups

Group	N	M	SD	SE	t	df	p	Mean Diff	95% CI
Experimental	30	0.42	0.84	0.15	0.11	42.19	.914	0.038	[0.738, 0.663]
Control	30	0.46	1.71	0.31					

Note. M = Mean; SD = Standard Deviation; SE = Standard Error; CI = Confidence Interval..

These findings suggest that the intervention did not result in a significant change in psychological well-being compared to the control group.

Follow Up Comparisons

To investigate changes from post-test to follow-up within each group, two paired samples t-tests were conducted.

Experimental Group (Post vs. Follow-Up)

The results indicated a statistically significant decrease in scores from post-test (M = 7.34, SD = 0.43) to follow-up (M = 6.78, SD = 0.94), $t(29) = 2.79$, $p = .009$, 95% CI [0.15, 0.98], $d = 0.51$. The mean difference was 0.56 points, suggesting a moderate reduction in scores over time.

Control Group (Post vs. Follow-Up)

The control group showed a statistically significant increase in scores from post-test (M = 6.48, SD = 1.01) to follow-up (M = 7.32, SD = 0.58), $t(29) = –4.07$, $p < .001$, 95% CI [–1.27, –0.42], $d = –0.74$. The mean increase of –0.85 points indicates a large and significant change over time.

These results suggest that while the experimental group showed a moderate decrease, the control group significantly improved their scores from post-test to follow-up. This inverse pattern may suggest that the intervention did not have the intended effect, or other external factors contributed to the control group's improvement.

Table 54. Descriptive Statistics for Post-Test and Follow-Up Scores

Group	Time Point	N	M	SD	SE
Experimental	Post-Test	30	7.34	0.43	0.08
Experimental	Follow-Up	30	6.78	0.94	0.17
Control	Post-Test	30	6.48	1.01	0.19
Control	Follow-Up	30	7.32	0.58	0.11

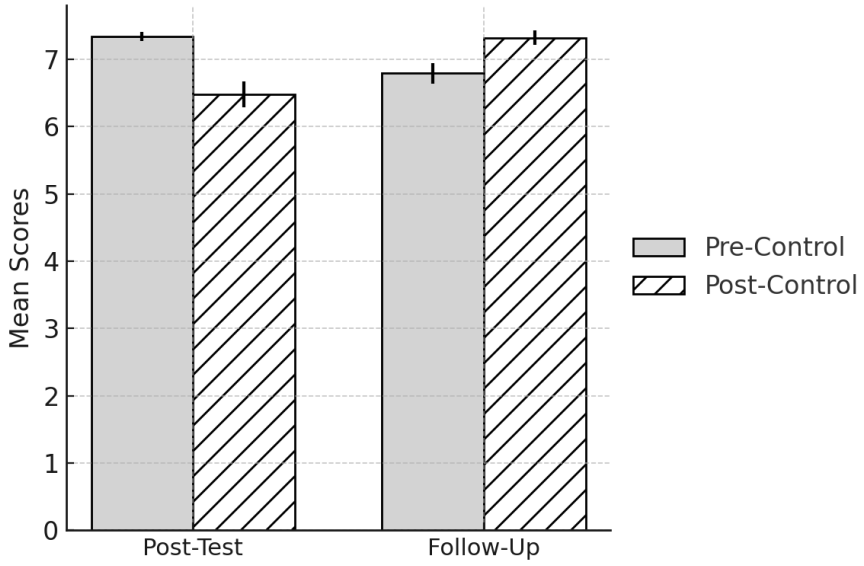
Note. M = Mean; SD = Standard Deviation; SE = Standard Error.

Table 55. Paired Samples t-Test Results

Group	t	df	p	Mean Diff	SD Diff	SE Diff	95% CI [LL,UL]		
Experimental	2.79	29	.009	0.56	1.11	0.20	0.15	0.98	0.51
Control	–4.07	29	< .001	–0.85	1.14	0.21	–1.27	–0.42	–0.74

Note. CI = Confidence Interval. Cohen's d calculated using standard deviation of the difference.

Figure 23. Post-Test and Follow-Up Scores by Group



1.1.1. Perceived Stress

Pre Experimental – Post Experimental Comparisons

A one-way between-subjects ANOVA was conducted to examine the effect of the intervention on perceived stress levels, as measured by the Perceived Stress Scale (PSS-10). The scale includes ten items, of which four (Items 4, 5, 7, and 8) are positively worded

and were reverse-scored prior to analysis to ensure that higher total scores reflect greater perceived stress. Given the 5-point Likert response format ranging from 1 (never) to 5 (very often), reverse scoring was performed using the formula 6 minus the original item value.

Descriptive statistics indicated that participants in the pre-experimental group reported significantly higher stress levels ($M = 3.65$, $SD = 0.37$) than post-experimental group participants ($M = 2.14$, $SD = 0.32$). This difference was statistically significant, $F(1, 58) = 292.22$, $p < .001$, partial $\eta^2 = .83$, indicating a significant effect of the intervention on reducing perceived stress.

Table 56. Descriptive Statistics and Mean Perceived Stress Scores Before and After the Intervention

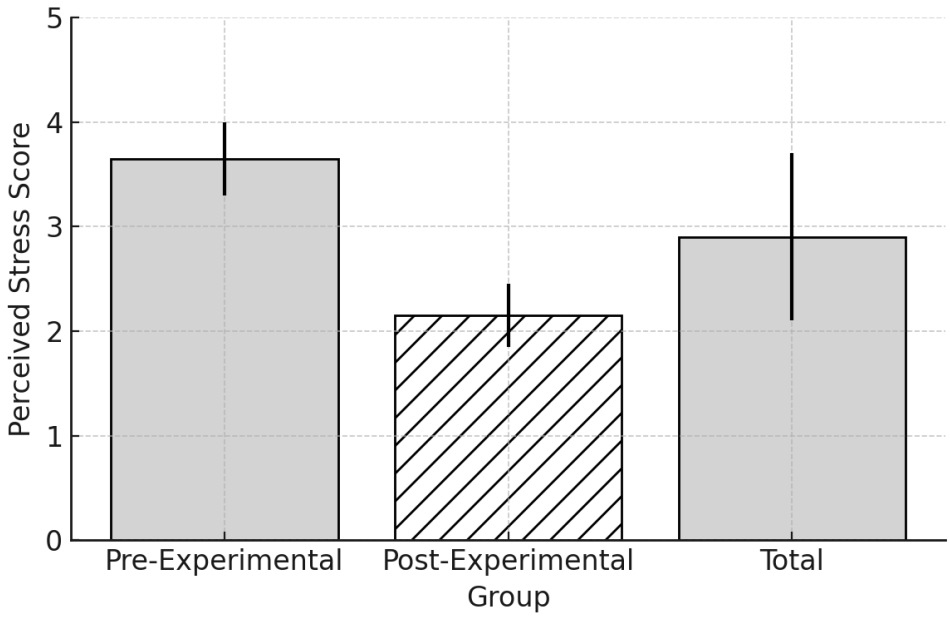
Group	Mean	Standard Deviation	N
Pre-Experimental	3.6533	0.36647	30
Post-Experimental	2.1433	0.31588	30
Total	2.8983	0.83351	60

Table 57. One-Way ANOVA Summary for the Effect of Group on Perceived Stress Scores

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial η^2
Corrected Model	34.201	1	34.201	292.22	0	0.83
Intercept	504.02	1	504.02	4306.384	0	0.98

Group	34.202	1	34.202	292.22	0	0.83
Error	6.788	58	0.117			
Total	545.01	60				
Corrected	40.99	59				
Total						

Figure 24. Mean Perceived Stress Scores by Group



Pre-Control – Post-Control Comparisons

Descriptive statistics indicated that participants in the Pre-Control group reported higher levels of perceived stress (M = 36.97, SD = 6.73, *n* = 30) compared to those in the Post-Control group (M = 31.93, SD = 9.74, *n* = 30). The overall mean stress score across both groups was 34.45 (SD = 8.68, *N* = 60).

Table 58. Descriptive Statistics for Perceived Stress Scores by Group

Group	Mean	Std. Deviation	N
Pre-Control	36.9667	6.73377	30
Post-Control	31.9333	9.74479	30
Total	34.45	8.68356	60

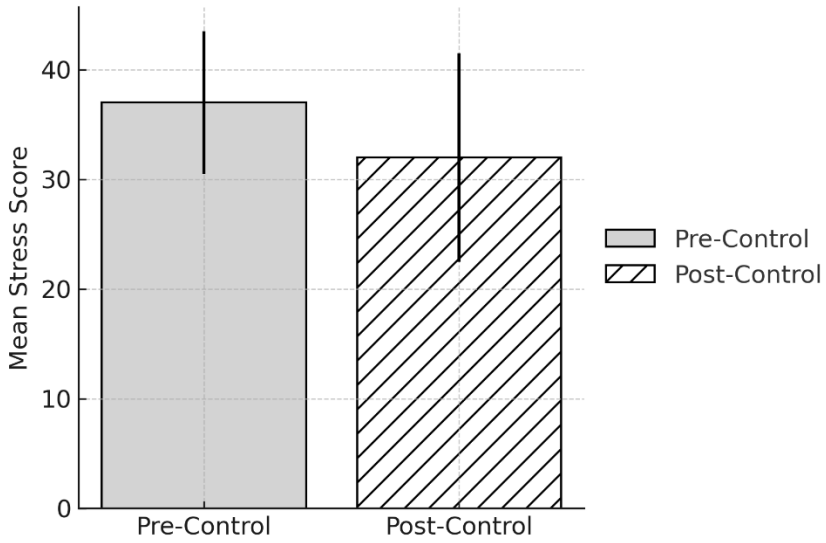
Note. M = mean; SD = standard deviation.

A one-way between-subjects ANOVA was conducted to examine the effect of group membership (Pre-Control vs. Post-Control) on total perceived stress scores. The analysis revealed a statistically significant difference between the groups, $F(1, 58) = 5.42$, $p = .023$, $\eta^2_p = .085$. This suggests that group membership had a moderate effect on perceived stress, with the Post-Control group reporting significantly lower stress levels than the Pre-Control group.

Table 59. One-Way ANOVA Summary for the Effect of Group on Perceived Stress Scores

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial η^2
Corrected Model	380.017	1	380.017	5.417	0.023	0.085
Intercept	71208.15	1	71208.15	1015.051	0	0.946
Group	380.017	1	380.017	5.417	0.023	0.085
Error	4068.833	58	70.152			
Total	75657	60				
Corrected Total	4448.85	59				

Figure 25. Mean Perceived Stress Scores by Group



Post Experimental – Post Control Comparisons

An independent samples t-test was conducted to compare the difference in perceived stress scores between the experimental and control groups. The results showed a statistically significant difference, with the experimental group ($M = –0.09$, $SD = 0.48$) showing a greater reduction in stress compared to the control group ($M = 0.87$, $SD = 0.55$), $t(58) = –7.17$, $p < .001$. The mean difference was –0.96, with a 95% confidence interval ranging from –1.23 to –0.69.

Table 60. Independent Samples t-Test Comparing Stress Score Differences Between Experimental and Control Groups

Group	N	M	SD	SE	t	df	p	Mean Diff	95% CI
Experimental	30	0.09	0.48	0.088	7.17	57.03	< .001	–0.96	[–1.23, 0.69]
Control	30	0.87	0.55	0.101					

Note. M = Mean; SD = Standard Deviation; SE = Standard Error; CI = Confidence Interval.

These results indicate that the CBT and ACT interventions significantly reduced perceived stress levels among participants in the experimental group compared to the control group.

Follow-Up Comparisons

To assess whether scores changed significantly between post-test and follow-up, two paired samples t-tests were conducted separately for the experimental and control groups.

Experimental Group (Post vs. Follow-Up)

There was no statistically significant difference between post-test scores (M = 3.32, SD = 0.26) and follow-up scores (M = 3.40, SD = 0.28) in the experimental group, $t(29) = -1.66$, $p = .108$, 95% CI [–0.18, 0.02], $d = -0.30$. Although the mean score increased slightly by 0.08 points, this difference was not statistically significant, indicating a small, non-conclusive trend toward improvement.

Control Group (Post vs. Follow-Up)

The control group also showed no statistically significant difference between post-test (M = 3.19, SD = 0.97) and follow-up scores (M = 3.41, SD = 0.41), $t(29) = -1.14$, $p = .266$, 95% CI [–0.60, 0.17], $d = -0.21$. The mean increase of 0.21 points was similarly small and not statistically meaningful.

Both groups showed small, non-significant increases in scores from post-test to follow-up. These results indicate that neither the intervention nor its absence of it produced a statistically detectable change in this outcome measure over the study period.

Table 61. Descriptive Statistics for Post-Test and Follow-Up Scores

Group	Time Point	N	M	SD	SE
Experimental	Post-Test	30	3.32	0.26	0.05
Experimental	Follow-Up	30	3.40	0.28	0.05
Control	Post-Test	30	3.19	0.97	0.18
Control	Follow-Up	30	3.41	0.41	0.07

Note. M = Mean; SD = Standard Deviation; SE = Standard Error.

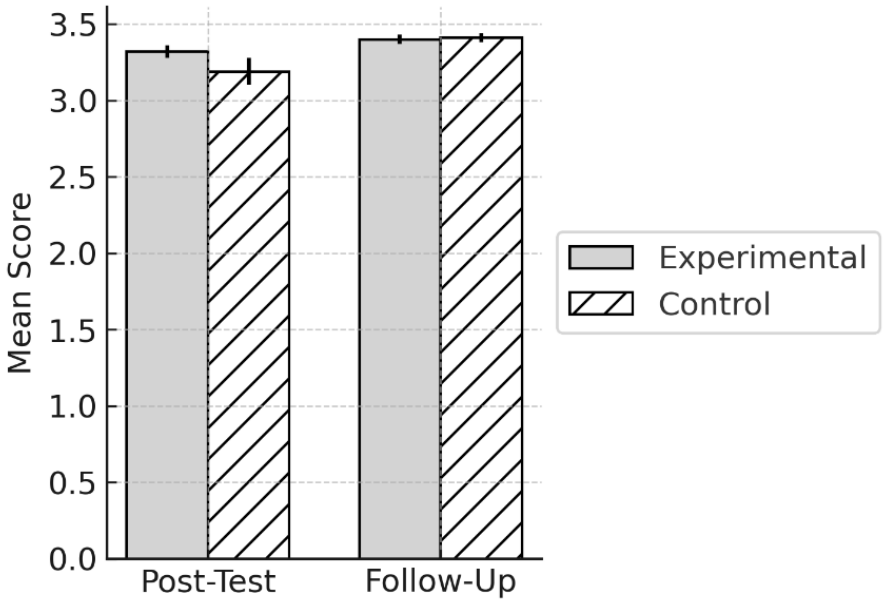
Table 62. Paired Samples t-Test Results

Group	t	df	p (2-tailed)	Mean Diff	SD Diff	SE Diff	95% CI [LL,UL]		Cohen's d
Experimental	–1.66	29	.108	–0.08	0.26	0.05	–0.18	0.02	–0.30

Control	– 1.14	29	.266	–0.21	1.03	0.19	–0.60	0.17	–0.21

Note. CI = Confidence Interval. Cohen's d calculated using the standard deviation of the difference.

Figure 26. Post-Test and Follow-Up Scores by Group



3.5.Discussion

The present study aimed to develop and evaluate the effectiveness of an integrated Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT)-based group intervention designed to improve the psychological well-being of women exposed to emotional abuse in their intimate relationships. The intervention was specifically developed to target four key outcomes identified in both the literature and pilot program feedback: perceived stress, psychological well-being, emotion regulation, and

emotional abuse perpetration and victimization. This aim was informed by a growing body of research indicating that emotional abuse—though often invisible and under-recognized—can have consequences equal to or more damaging than physical violence, particularly in its chronic and pervasive forms (Ersanli et al., 2013; Murphy & Hoover, 1999; Öngün & Uysal, 2018).

In the Turkish context, emotional abuse in intimate partner relationships is a widespread yet insufficiently addressed phenomenon. Studies have documented high prevalence rates, with estimates suggesting that between 40% and 50% of women experience some form of psychological violence during their lifetime (Bozkurt et al., 2023; Hatunoglu et al., 2014). Despite these rates, cultural norms, traditional gender roles, and the absence of explicit legal recognition of emotional abuse as a distinct form of violence contribute to its invisibility (Fidan & Yeşil, 2018; Sünetçi et al., 2016). The psychological literature has shown that emotional abuse leads to heightened stress reactivity, impaired emotion regulation, reduced self-esteem, and deterioration in overall well-being (Loring, 1994; Arabaci & Uygun, 2022; Estefan et al., 2016). Against this backdrop, the present study sought to fill a critical gap by providing an empirically grounded, culturally adapted intervention tailored to this population.

The study tested four hypotheses. Hypothesis 1 stated that there would be a significant difference in perceived stress levels between women who undergo the CBT- and ACT-based intervention and those in the control group. Hypothesis 2 proposed that there would be a significant difference in psychological well-being between women who participate in the intervention and those in the control group. Hypothesis 3 stated that there would be a significant difference in emotion regulation between women who complete the

intervention and those in the control group. Hypothesis 4 proposed that there would be a significant difference in emotional abuse scores between women who receive the intervention and those in the control group.

The findings provided strongly supported for Hypotheses 1, 3, and 4, while Hypothesis 2 was partially supported. Across the primary outcomes, the intervention group experienced large and statistically significant improvements from pre- to post-test, many of which were maintained at follow-up, demonstrating both program's short-term efficacy and potential durability.

Cognitive Emotion Regulation

The most robust improvements were observed in cognitive emotion regulation, consistent with Hypothesis 3. The intervention produced significant reductions in maladaptive strategies such as self-blame, blaming others, rumination, catastrophizing, and passive acceptance, alongside significant increases in adaptive strategies including positive reappraisal, refocus on planning, positive refocusing, and putting into perspective. This outcome is highly consistent with theoretical models linking emotional abuse to cognitive processing deficits—particularly those emphasizing how persistent exposure to demeaning, controlling, and invalidating behaviors shapes maladaptive thinking patterns and impairs emotional self-regulation (Eckhardt et al., 2013).

From a therapeutic standpoint, integrating of CBT and ACT processes may have been particularly critical. CBT provided participants with skills to identify and challenge distorted beliefs that often emerge in abusive contexts—such as self-blame (“It’s my fault I’m treated this way”) or catastrophic interpretations of conflict. ACT complemented these

skills by promoting mindfulness, acceptance, and cognitive defusion, enabling participants to observe distressing thoughts without becoming entangled in them (Hayes, 2004; Resick et al., 2012). This combination aligns with recent evidence suggesting that psychological flexibility is a core protective factor against the mental health consequences of IPV (Luoma et al., 2007).

The durability of this emotion regulation gains at follow-up suggests that the intervention fostered immediate skill acquisition and also internalized coping strategies that participants could apply in real-life contexts beyond the group setting. In contrast, the control group exhibited declines in adaptive strategies and increases in maladaptive ones, highlighting the potential worsening of coping capacities of without of targeted intervention.

3.5.1. Emotional Abuse: Perpetration and Victimization

The program's significant impact on emotional abuse perpetration and victimization scores (Hypothesis 4) is noteworthy given the bidirectional patterns documented in the literature (Jordan et al., 2010). While emotional abuse is often framed exclusively in terms of victimization, research suggests that survivors may also engage in retaliatory or defensive forms of emotionally abusive behavior, perpetuating a cycle of relational harm (Carney & Barner, 2012).

In the present study, reductions across all eight MMEA subscales suggest that participants not only became less likely to tolerate abusive behaviors from others but also less likely to engage in such behaviors themselves. This outcome reflects the combined effects of psychoeducation—raising awareness of what constitutes abuse—and skills

training in assertive communication, boundary-setting, and conflict resolution. This shift in perception is especially meaningful in cultural contexts such as Türkiye, where controlling behaviors may be normalized or even valorized as signs of care (Fidan & Yeşil, 2018).

3.5.3. Psychological Well-Being (PERMA)

While Hypothesis 2 was only partially supported, the within-group improvements in Positive Emotion, Relationships, Meaning, Accomplishment, and Health are consistent with the literature on positive psychology interventions and the use of CBT and ACT to enhance well-being (Seligman, 2011; Banks et al., 2015). The reduction in Negative Emotion and Loneliness in the intervention group further underscores the potential of process-based interventions to counteract the social withdrawal and hopelessness often induced by emotional abuse (Loring, 1994; Arabaci & Uygun, 2022).

However, the absence of significant between-group differences in overall well-being change scores warrants consideration. Well-being is a multidimensional construct influenced by numerous life domains—including socioeconomic stability, physical health, and social networks—that the intervention may not have directly targeted. Additionally, the moderate decline in the intervention group's well-being scores at follow-up, alongside improvements in the control group, could reflect a "post-intervention awareness effect" in which increased insight into relational challenges temporarily reduces subjective well-being.

3.5.4. Perceived Stress

Hypothesis 1 was strongly supported, with large reductions in perceived stress observed in the intervention group and maintained at follow-up. Given that chronic stress is a well-documented consequence of IPV and a mediator between abuse and adverse health outcomes (Jacobson et al., 1996; Valizadeh & Ahmadi, 2022), this result is clinically significant. The stress-reducing effects of CBT (through cognitive restructuring and problem-solving) and ACT (through mindfulness and acceptance) are well established (Reivich & Shatté, 2002; Hayes, 2004), and the integration of both may have maximized their impact in this context.

3.5.5. Intervention Development and Refinement: From Pilot to Final Program

The intervention was developed following a pilot program, which provided essential insights into content delivery, participant needs, and program feasibility. The pilot program incorporated elements of Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT) alongside psychoeducational and skills-based activities aimed at raising awareness of emotional abuse, recognizing abusive behaviors, and introducing coping strategies. Weekly topics addressed boundaries, communication styles, resilience, and self-care, with activities such as "Ten Things in Common," boundary-setting exercises, and feelings identification. While mindfulness and stress management—integral to both CBT and ACT—were included, therapeutic techniques were applied in a more general, unstructured manner, and the program's overall orientation remained largely awareness-focused rather than process-driven.

Feedback from the pilot revealed that although psychoeducation increased awareness, participants continued to struggle with intrusive thoughts, intense emotions, and avoidance behaviors in daily life. Follow-up observations indicated that behavioral and

cognitive changes were difficult to sustain without a structured therapeutic framework. These insights, together with the current study's aim to measure outcomes such as emotion regulation, perceived stress, emotional abuse scores, and well-being, led to a redesign of the program to target psychological processes linked to these outcomes more directly.

The final program was restructured into a nine-session format explicitly grounded in CBT and ACT principles. Sessions followed a therapeutic progression—beginning with trust-building and psychoeducation, moving into mindfulness, acceptance, and cognitive defusion to reduce reactivity to distressing thoughts, and advancing toward values clarification, behavioral activation, self-compassion, and relapse prevention. CBT techniques (e.g., cognitive restructuring, behavioral activation) targeted maladaptive cognitive patterns and avoidance behaviors, while ACT processes (e.g., mindfulness, acceptance, values-based action) enhanced psychological flexibility and resilience.

This evolution represented a shift from a loosely structured, awareness-oriented program to a theory-driven, process-based intervention designed to produce measurable clinical change. The strong results observed in the present study, particularly in emotion regulation and reductions in emotional abuse, suggest that this theoretical integration and process orientation were central to the program's effectiveness.

3.5.6. **Limitations**

Several limitations of the present study should be acknowledged to provide an accurate interpretation of the findings and to guide future research.

First, the sample consisted exclusively of married Turkish women, recruited from a relatively homogeneous socio-cultural context. While this focus allowed for a culturally

tailored intervention, it also limits the generalizability of the results to other populations, including men, unmarried women, individuals in same-sex relationships, and survivors from different cultural, ethnic, or socio-economic backgrounds. Previous research has highlighted that experiences of emotional abuse, as well as coping mechanisms and help-seeking behaviors, can vary considerably across gender, marital status, and cultural norms (Ali & Naylor, 2013; Fidan & Yeşil, 2018). Expanding participant diversity in future trials is essential to understand understand this intervention's broader applicability.

Second, all data were collected using self-report measures, including the Multidimensional Measure of Emotional Abuse (MMEA) for both perpetration and victimization. While these instruments have demonstrated good psychometric properties, self-report methodologies are inherently vulnerable to biases such as social desirability and recall inaccuracies. In the context of IPV, underreporting of perpetration behaviors is common due to stigma, self-image concerns, or fear of judgment, and overreporting of change might occur due to perceived expectations from researchers or therapists (Straus, 2012). Future research should incorporate multi-method assessment approaches, such as behavioral coding of role-play interactions, collateral reports from trusted individuals, or ecological momentary assessment (EMA), to triangulate findings.

Third, the follow-up period in this study was relatively short, limiting conclusions about the long-term sustainability of intervention effects. While gains in emotion regulation, perceived stress, and emotional abuse scores were maintained at follow-up, it is unknown whether these improvements would persist over six months, one year, or longer. Given that emotional abuse patterns can re-emerge under stress or life transitions, long-term follow-up is critical for evaluating relapse prevention efficacy.

Fourth, the absence of an active control group—such as a group receiving supportive counseling, psychoeducation-only, or a different therapeutic modality—means that we cannot fully isolate the specific contribution of CBT and ACT processes from non-specific therapeutic factors. It is possible that group cohesion, mutual support, and validation from peers contributed to some of the observed improvements (Yalom & Leszcz, 2005). Future studies should employ active comparator designs to clarify the unique and additive value of integrated CBT–ACT interventions.

Finally, while integrating of CBT and ACT was intentional and theoretically grounded, the present study did not conduct a component analysis to identify which specific intervention elements (e.g., cognitive restructuring, mindfulness, values clarification) were most strongly associated with change. Understanding active ingredients would inform streamlined, cost-effective adaptations for broader implementation.

3.5.7. Future Directions

Building on the promising results of this study, several directions for future research emerge.

First, replication studies should aim to diversify participant samples, including men, unmarried individuals, survivors from rural and urban settings, and members of marginalized or minority communities. This would provide insight into cultural and relational factors that influencing intervention uptake and effectiveness. Comparative studies across countries could also examine how sociocultural norms about gender, marriage, and abuse shape intervention outcomes.

Second, extending the follow-up period is essential to assess the stability of intervention gains. Studies should include multiple follow-up points (e.g., 3, 6, and 12 months) and consider implementing booster sessions at strategic intervals to reinforce skills and prevent relapse. Evidence from other IPV-related interventions suggests that booster sessions can significantly enhance maintenance of gains (Sullivan et al., 2002).

Third, dismantling studies comparing CBT-only, ACT-only, and integrated CBT–ACT formats could help clarify the unique contribution of each theoretical approach to observed outcomes. Such studies would advance both clinical theory and practical decision-making for service providers who must balance therapeutic depth with resource constraints.

Fourth, future research should integrate qualitative components, such as semi-structured interviews or focus groups, to capture participants' subjective experiences, perceived barriers, and the most valued aspects of the intervention. These narratives can illuminate mechanisms of change that quantitative measures may miss, and they can guide refinements for improved cultural resonance and engagement.

Finally, implementation of research is needed to explore scalability and real-world delivery. This includes testing the intervention in community mental health centers, NGOs, and online formats, as well as evaluating cost-effectiveness. Digital adaptations could increase accessibility for survivors in remote areas or those unable to attend in-person groups due to safety or childcare concerns.

3.5.8. Practical Implications

The significant effects of the intervention on emotion regulation, perceived stress, and both perpetration and victimization of emotional abuse have important clinical, community, and policy implications.

From a clinical practice perspective, the findings suggest that a structured, integrated CBT–ACT group format can provide survivors of emotional abuse with both the cognitive tools and the psychological flexibility needed for recovery. This approach moves beyond raising awareness—common in many IPV programs—by targeting the processes that maintain maladaptive relational patterns, such as rumination, avoidance, and rigid thinking. The emphasis on both reducing harmful cognitive patterns (CBT) and promoting acceptance and values-based action (ACT) may be particularly useful for individuals experiencing chronic, non-physical forms of IPV that are often dismissed or minimized in traditional services.

The program offers a replicable and adaptable model for community-based organizations and IPV service providers. Its group format allows for efficient use of resources while fostering peer support, which research has shown to enhance engagement and perceived safety (Goodman & Smyth, 2011). The structured session-by-session manualization also supports fidelity in delivery, making it suitable for training paraprofessionals under supervision.

From a policy standpoint, these results reinforce the need to formally recognize emotional abuse as a distinct and serious public health concern. Despite its prevalence and documented mental health consequences, emotional abuse remains underrepresented in legislation and policy frameworks, both in Türkiye and globally. Policymakers should allocate funding for culturally sensitive, evidence-based interventions, and include

emotional abuse prevention and recovery programs in national IPV strategies. This aligns with WHO (2020) recommendations that IPV interventions must address psychological as well as physical and sexual forms of abuse.

3.5.9. Conclusion

This study provides robust empirical evidence that a structured, culturally adapted CBT–ACT group intervention can effectively reduce emotional abuse perpetration and victimization, improve emotion regulation, and lower perceived stress among married Turkish women exposed to IPV. Although changes in overall psychological well-being were mixed, the magnitude of improvements in targeted psychological and behavioral outcomes underscores the program's clinical value.

A key strength of the present research lies in evolving of the intervention from a primarily awareness-focused pilot program into a theory-driven, process-based therapeutic model. This refinement—grounded in empirical literature and informed by pilot feedback—ensured that the intervention addressed both the content (e.g., challenging maladaptive beliefs) and the process (e.g., increasing acceptance and flexibility) of change. Integrating CBT's cognitive restructuring techniques with ACT's mindfulness and values-based action strategies appears to have been instrumental produced these results, consistent with emerging evidence on the benefits of process-based therapy approaches (Hayes et al., 2021).

By targeting the often-overlooked form of IPV that is emotional abuse, and demonstrating meaningful change in both experiential and behavioral domains, this study offers a replicable, evidence-based model for clinical and community settings. While

further research is needed to expand generalizability, examine long-term effects, and identify active ingredients, the current findings contribute to closing a critical gap in IPV intervention science—one with the potential to inform practice and policy both within Türkiye and internationally.

4. GENERAL DISCUSSION

The present study aimed to develop and evaluate a culturally adapted group intervention integrating Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT) to address the psychological needs of married Turkish women who have experienced emotional abuse in intimate partner relationships. The intervention was deliberately designed to target four empirically grounded outcome domains—perceived stress, psychological well-being, emotion regulation, and emotional abuse perpetration and victimization—based on both prior literature and feedback from a pilot program. The study tested four hypotheses. Hypothesis 1 stated that there would be a significant difference in perceived stress levels between women who undergo the CBT- and ACT-based intervention and those in the control group. Hypothesis 2 proposed that there would be a significant difference in psychological well-being between women who participate in the intervention and those in the control group. Hypothesis 3 stated that there would be a significant difference in emotion regulation between women who completed the intervention and those in the control group. Hypothesis 4 proposed that there would be a significant difference in emotional abuse scores between women who received the intervention and those in the control group.

The findings offer compelling evidence for the intervention's effectiveness in several key areas, and reveal important nuances that inform theory, clinical practice, and policy.

4.5. Interpreting the Core Findings

The most consistent and robust improvements emerged in cognitive emotion regulation, supporting Hypothesis 3. Participants in the intervention group demonstrated substantial reductions in maladaptive cognitive strategies, such as self-blame, blaming others, rumination, catastrophizing, and passive acceptance, accompanied by notable increases in adaptive strategies including positive reappraisal, refocusing on planning, positive refocusing, and putting problems into perspective. This aligns with theoretical models of emotional abuse emphasizing how persistent exposure to controlling, demeaning, and invalidating behaviors erodes cognitive flexibility and fosters maladaptive processing patterns (Eckhardt et al., 2013). The durability of these gains at follow-up suggests that participants not only acquired new coping strategies but also internalized them sufficiently to apply them in everyday contexts, potentially interrupting the cognitive–emotional cycles that sustain abuse-related distress.

From a process perspective, the integrated CBT–ACT approach may have produced these results. CBT components—particularly cognitive restructuring—helped participants identify and challenge distorted beliefs often internalized in abusive contexts (e.g., “I am to blame for being treated this way,” or interpreting conflict catastrophically). ACT processes complemented these skills by fostering mindfulness, acceptance, and cognitive defusion, enabling participants to observe distressing thoughts without over-identifying with them (Hayes, 2004; Resick et al., 2012). This combination appears to support the development of psychological flexibility, which recent literature identifies as a protective factor against the mental health consequences of intimate partner violence (Luoma et al., 2007).

The reductions in both emotional abuse perpetration and victimization (Hypothesis 4) also represent an important outcome. Research has increasingly recognized the bidirectional nature of some emotionally abusive interactions (Jordan et al., 2010; Carney & Barner, 2012). In the present study, improvements across all eight MMEA subscales indicate that participants became less likely to tolerate emotionally abusive behaviors from others and less likely to engage in them themselves. These changes were likely facilitated by psychoeducation on the definitions and manifestations of abuse, coupled with skills training in assertive communication, boundary-setting, and conflict resolution. Such findings are particularly relevant in cultural contexts where certain controlling behaviors may be normalized or perceived as signs of care (Fidan & Yeşil, 2018).

In terms of perceived stress (Hypothesis 1), the intervention group showed large and sustained reductions from pre-test to follow-up. This is notable given that chronic stress serves as a mediator between abuse and adverse mental and physical health outcomes (Jacobson et al., 1996; Valizadeh & Ahmadi, 2022). The combined stress-reducing potential of CBT's cognitive restructuring and problem-solving techniques and ACT's mindfulness and acceptance strategies likely contributed to these gains (Reivich & Shatté, 2002; Hayes, 2004).

Findings for psychological well-being (Hypothesis 2) were more complex. While the intervention group demonstrated significant within-group improvements in Positive Emotion, Relationships, Meaning, Accomplishment, and Health, between-group differences in overall well-being change scores were not significant. This may reflect the multidimensional nature of well-being, which can be influenced by factors beyond the intervention's scope, such as financial stability, physical health, and broader social

supports. Additionally, the moderate decline in well-being scores at follow-up, alongside improvements in the control group, could be explained by a "post-intervention awareness effect," wherein increased insight into relational challenges temporarily diminishes subjective well-being.

4.6. Group Process, Cultural Sensitivity, and Yalom's Therapeutic Factors

Attendance and engagement in the intervention group were exceptionally high, with no participant missing a session. This consistent attendance is notable in IPV interventions, where barriers such as childcare responsibilities, stigma, or safety concerns often impede participation. The high retention may reflect the relevance of the intervention's content and the group's ability to create a safe, culturally resonant environment that encourages ongoing involvement.

A particularly salient cultural dimension emerged organically: each week, participants brought homemade foods—such as biscuits, pastries, and other traditional Turkish treats—to share with the group. In the Turkish context, such gestures are deeply rooted in values of *misafirperverlik* (hospitality), generosity, and communal care. Sharing food is not simply an act of nourishment but a social ritual that communicates welcome, respect, and solidarity. Within the group therapy framework, these culturally meaningful acts were as more than informal courtesies—they became active ingredients in group cohesion and trust-building.

This tradition aligns strongly with several of Yalom's 11 therapeutic factors (Yalom & Leszcz, 2005). Most directly, the practice reflected altruism (Factor 4), as members engaged in tangible acts of giving without expectation of reciprocity, fostering a sense of value and contribution. It also reinforced group cohesiveness (Factor 9), as the shared

experience of enjoying traditional foods created moments of collective identity and belonging, transcending the therapeutic content and strengthening interpersonal bonds.

Additionally, these exchanges may have facilitated universality (Factor 2), reminding participants of shared cultural roots and life experiences, thus reducing isolation and reinforcing the perception of being understood within one's cultural frame. For some, preparing and sharing food might have provided a corrective emotional experience akin to corrective recapitulation of the primary family group (Factor 5), offering a nurturing, nonjudgmental social microcosm in contrast to the controlling or invalidating dynamics often experienced in abusive relationships.

From a cultural sensitivity perspective, the intervention benefited from acknowledging and embracing these organic group processes rather than viewing them as distractions from the "formal" therapeutic agenda. Integrating culturally congruent rituals into group settings can deepen trust, enhance openness, and support interpersonal learning (Factor 8) by allowing participants to observe and participate in pro-social, culturally resonant interactions. In collectivist cultures such as Türkiye, these shared rituals may be particularly potent in reinforcing a sense of "togetherness consciousness," where mutual care and communal sharing are integral to healing.

In summary, the unplanned tradition of sharing homemade foods exemplified how culturally embedded practices can enrich therapeutic outcomes. It amplified several of Yalom's therapeutic factors and anchored the intervention in the participants' lived cultural context, enhancing relevance, engagement, and retention. This underscores the importance of designing and facilitating flexible interventions to incorporate culturally meaningful behaviors, allowing natural social processes to become vehicles for change.

4.7. Broader Theoretical and Clinical Implications

The present study makes several important contributions to the growing body of literature on emotional abuse and its treatment. From a theoretical perspective, the findings reinforce the notion that interventions addressing both cognitive content (as emphasized in CBT) and contextual psychological processes (as emphasized in ACT) can produce meaningful change in both relational behaviors and individual psychological functioning. Emotional abuse is a multifaceted phenomenon, often maintained by entrenched cognitive distortions (e.g., self-blame, catastrophizing) and by maladaptive patterns of avoidance and experiential suppression. Combining CBT's emphasis on identifying and restructuring maladaptive thoughts with ACT's focus on mindfulness, acceptance, and values-based action, the present intervention offered a comprehensive approach to dismantling these reinforcing cycles.

Importantly, the program addressed both victimization and perpetration of emotional abuse. This approach moves beyond the traditional dichotomy of "abuser" and "victim" and instead recognizes the bidirectional and interactional dynamics that can characterize emotionally abusive relationships (Carney & Barner, 2012; Murphy & O'Leary, 1989). This dual focus is particularly relevant in cultures and relationship contexts where controlling, shaming, or withdrawing behaviors may be normalized or reciprocated in conflict situations. By helping participants to (1) recognize abusive patterns regardless of the role they occupy in the interaction, and (2) replace those behaviors with healthier relational strategies, the intervention supports survivors in breaking cycles of harm rather than simply exiting them.

Clinically, the study's findings support the utility of integrated, process-based group interventions for addressing non-physical forms of intimate partner violence (IPV), which have historically been marginalized in both research and service provision. When facilitated effectively, group formats can offer unique therapeutic benefits such as normalization of experiences, mutual validation, and opportunities to practice new skills in a supportive environment (Yalom & Leszcz, 2005). The structured, manualized nature of the program also enhances scalability and fidelity, making it a feasible option for a range of service delivery settings—including community mental health centers, women's shelters, and NGO-based IPV programs.

The study also demonstrates that cultural adaptation does not require sacrificing theoretical rigor. The intervention was explicitly designed to align with married Turkish women's lived experiences and sociocultural realities, while remaining firmly grounded in empirically supported CBT and ACT principles. This balance between cultural sensitivity and evidence-based practice is crucial in IPV intervention work, as overly generic programs may fail to resonate with participants. In contrast, culture-specific initiatives risk neglecting the broader psychological mechanisms driving change.

Finally, the results underscore the importance of considering emotional abuse as a distinct clinical target within IPV prevention and recovery efforts. While many programs focus primarily on physical and sexual violence, the chronic and pervasive nature of emotional abuse means that its psychological consequences—such as impaired emotion regulation, heightened stress reactivity, and erosion of self-worth—can persist long after physical violence has ceased. By demonstrating measurable improvements in these domains, the present study provides a model for addressing an often-overlooked form of

IPV. It highlights the potential of integrated therapeutic frameworks to produce lasting, meaningful change.

4.8. Limitations and Considerations for Future Research

Despite its strengths, the study has several noteworthy when interpreting the findings. First, the homogeneity of the sample—comprising exclusively married Turkish women from relatively similar socio-cultural and socio-economic backgrounds—significantly limits the generalizability of the results. While this focus allowed for targeted cultural adaptation and relevance, it restricts the applicability of the findings to other populations, including unmarried women, men, individuals in same-sex relationships, or survivors from different ethnic, socio-economic, and religious backgrounds. Given that cultural norms and relationship expectations can shape both the experience of emotional abuse and the effectiveness of therapeutic interventions, replication with more diverse samples is necessary to establish broader external validity.

Second, the study relied solely on self-report measures to assess key constructs such as emotional abuse perpetration and victimization, perceived stress, psychological well-being, and cognitive emotion regulation. While the selected instruments (e.g., MMEA, CERQ, PSS, PERMA) possess strong psychometric properties, self-report data are inherently vulnerable to social desirability bias, recall inaccuracies, and self-perception distortions. In domains as sensitive as IPV perpetration, participants may consciously or unconsciously underreport abusive behaviors due to stigma, fear of judgment, or internalized shame, or conversely, overstate improvements due to perceived expectations from the research team or group facilitators. In future studies, incorporating multi-method assessment strategies—such as collateral partner reports, behavioral coding of role-play

interactions, or ecological momentary assessment (EMA)—could provide a more nuanced and objective picture of change.

Third, the follow-up period in this study was relatively short, which constrains conclusions about the long-term sustainability of intervention effects. Although many improvements were maintained at follow-up, it remains unclear whether these gains persist over extended periods (e.g., 6–12 months or beyond) or in the face of significant life stressors or relationship transitions. Longitudinal research is needed to examine the' durability of changes and determine whether periodic booster sessions might help sustain skills over time.

Fourth, the study employed a wait-list control group rather than an active control condition, meaning that the possibility of non-specific therapeutic factors contributing to the observed improvements cannot be fully excluded. Factors such as group cohesion, mutual support, validation of lived experiences, and mere participation in a structured intervention may have produced beneficial effects independent of the specific CBT–ACT techniques used (Yalom & Leszcz, 2005). An active comparator group receiving a different structured intervention—such as supportive counseling or psychoeducation without process-based components—would strengthen causal inferences regarding the unique contribution of the integrated CBT–ACT approach.

Finally, the study did not include a dismantling or component analysis to identify which elements of the integrated intervention were most influential in producing change. It remains unclear whether improvements in emotion regulation, stress, and emotional abuse were primarily driven by cognitive restructuring, mindfulness, values clarification, behavioral activation, or the synergistic combination of these techniques. Identifying active

ingredients would have practical implications for refining the intervention for efficiency, cost-effectiveness, and scalability in resource-limited settings.

3.6.Practical and Policy Implications

From a clinical perspective, the findings of this study underscore the necessity of moving beyond awareness-raising approaches toward interventions that actively target the cognitive, emotional, and behavioral processes that sustain distress in survivors of emotional abuse. While psychoeducation remains a vital first step in validating experiences and increasing recognition of abusive patterns, the present results demonstrate that awareness alone is insufficient for producing durable change. By integrating CBT's structured cognitive restructuring techniques with ACT's mindfulness, acceptance, and values-based action strategies, practitioners can address both the content of maladaptive thoughts and the context in which these thoughts and behaviors occur, thereby enhancing psychological flexibility and resilience.

The study provides a replicable, resource-efficient group intervention model for community organizations that is particularly well-suited for delivery in non-clinical settings such as women's centers, NGOs, and primary health care environments. The group format allows multiple participants to be reached simultaneously, reducing costs while fostering peer support, normalization, and shared learning—elements that are especially valuable for survivors who have experienced isolation as part of the abuse dynamic. The manualized structure of the program promotes fidelity and scalability, enabling trained facilitators to maintain intervention integrity across different regions and service contexts. Furthermore, the adaptability of the content means it could be modified for other

populations, such as men, adolescents, or mixed-gender groups, while retaining its core process-based framework.

At a policy level, the findings highlight the urgent need for explicit legal recognition of emotional abuse as a distinct form of intimate partner violence, consistent with international best practice frameworks (WHO, 2020). In many jurisdictions, including Türkiye, the lack of statutory definitions and enforcement mechanisms for psychological violence perpetuates its invisibility, leaving survivors without adequate legal recourse or protection. Incorporating emotional abuse into legal statutes would send a powerful message that psychological harm is as serious as physical harm and would compel the allocation of resources toward prevention and intervention efforts.

Moreover, national IPV strategies should integrate culturally sensitive, evidence-based interventions that specifically address emotional abuse. This includes funding for program dissemination, facilitator training, and public awareness campaigns that challenge the normalization of controlling, demeaning, or isolating behaviors. Partnerships between governmental agencies, academic institutions, and community organizations could facilitate large-scale implementation and rigorous evaluation of such programs. By embedding psychological abuse prevention and recovery into broader public health and gender equality agendas, policymakers can help shift both societal attitudes and service delivery practices toward more comprehensive support for survivors.

Finally, the results speak to the broader need for multi-sector collaboration in addressing emotional abuse. Legal reform, clinical intervention, and public education must operate in tandem to break the cycle of harm. The present study offers a practical, evidence-informed blueprint for one component of that effort. This structured, process-oriented

group program is culturally grounded, theoretically robust, and capable of producing meaningful change in the lives of survivors.

3.7.Conclusion

By integrating CBT and ACT within a culturally adapted, process-based group format, the present study demonstrates that it is possible to achieve meaningful and measurable reductions in both the experience and perpetration of emotional abuse, alongside substantial improvements in emotion regulation and perceived stress. These outcomes are especially notable given the complex, bidirectional, and often hidden nature of emotional abuse, which can persist undetected within intimate relationships and leave enduring psychological scars. The capacity of the intervention to produce such changes underscores the value of addressing both cognitive restructuring and acceptance-based processes, thereby targeting not only the content of distressing thoughts but also the individual's relationship with those thoughts and emotions.

While improvements in psychological well-being were more nuanced, the intervention's demonstrated ability to alter core cognitive, emotional, and behavioral processes represents a significant advance in IPV intervention science. The partial support for well-being gains highlights the importance of recognizing that this construct is influenced by multiple life domains, some of which extend beyond the scope of a group intervention, and points to potential benefits of integrating additional components targeting broader quality-of-life factors in future iterations.

The findings underscore the importance of iterative program development informed by empirical evidence and participant feedback. The evolution from an awareness-focused, activity-driven pilot to a theory-driven, process-oriented final program was instrumental in achieving the observed outcomes. This adaptive development process illustrates how interventions can be refined to meet participants' needs better while maintaining theoretical rigor and fidelity to evidence-based principles.

These results offer a replicable and scalable model with potential applications in diverse cultural and clinical contexts. The program's structured, manualized format and its grounding in well-established therapeutic models make it suitable for adaptation in various service delivery settings, from community-based organizations to specialized IPV treatment centers. Beyond its immediate clinical utility, the study contributes to the broader recognition of emotional abuse as a critical public health issue deserving of targeted, culturally sensitive, and theoretically robust intervention efforts.

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6. APPENDICES

6.1. APPENDIX-1: INFORMED CONSENT FORM IN THE FIRST AND THE SECOND STUDY

BİLGİLENDİRİLMİŞ ONAM FORMU

LÜTFEN BU DÖKÜMANI DİKKATLİCE OKUMAK İÇİN ZAMAN AYIRINIZ

Sizi **Gyulnaz Halil** tarafından yürütülen "**The Efficacy of Cognitive-Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT) in Mitigating the Effects of Emotional Abuse among Married Turkish Women: An Experimental Design Study** " başlıklı **araştırmaya** davet ediyoruz. Bu araştırmaya katılıp katılmama kararını vermeden önce, araştırmanın neden ve nasıl yapılacağını bilmeniz gerekmektedir. Bu nedenle bu formun okunup anlaşılması büyük önem taşımaktadır. Eğer anlayamadığınız ve sizin için açık olmayan şeyler varsa, ya da daha fazla bilgi isterseniz bize sorunuz.

Bu çalışmaya katılmak tamamen **gönüllülük** esasına dayanmaktadır. Çalışmaya **katılmama** veya katıldıktan sonra herhangi bir anda çalışmadan **çıkma** hakkında sahipsiniz. **Çalışmayı yanıtlamanız, araştırmaya katılım için onam verdiğiniz** biçiminde yorumlanacaktır. Size verilen **formlardaki** soruları yanıtlarken kimsenin baskısı veya telkini altında olmayın. Bu formlardan elde edilecek bilgiler tamamen araştırma amacı ile kullanılacaktır.

1. Araştırmayla İlgili Bilgiler:

a. Araştırmanın Amacı**:** Bu çalışma, evli Türk kadınlarının yaşadığı duygusal istismarın zararlı etkilerini ele almada Bilişsel-Davranışçı Terapi (BDT) ve Kabul ve Kararlılık Terapisinin (ACT) etkinliğini araştırmayı amaçlamaktadır. Araştırma, ruh sağlığı uygulayıcıları, politika yapıcılar ve yakın partner şiddetini önlemek için çalışan araştırmacılar için değerli bilgiler sunmayı amaçlıyor.

b. Araştırmanın İçeriği: İlk etapta bilgilendirilmiş onam verilecek ve sonrasında demografik form sunulacaktır. Aşağıdaki dahil etme ve hariç tutma kriterlerine göre:

- Katılım kriterleri: Katılmak için minimum 18 yaş gerekli olacaktır; Araştırmaya sadece evli kadınlar dahil edilecek; Sadece Türk kadın nüfusu dahil edilecek; Yalnızca duygusal istismar deneyimi olan evli kadınlar dahil edilecektir;

- Dışlanma kriterleri: Kısa Semptom Envanteri-KSE'den yüksek puan alan kadınlar araştırmaya dahil edilmeyecektir; fiziksel ve cinsel istismara maruz kalan kadınlar kapsam dışında tutulacak;

Katılımcılara dahil edilme kriterlerinin belirlenmesi için BSI ölçüm aracı verilecektir:

- Envanterden alınan puanların yüksek olması (0,62 ve üzeri) durumunda katılımcı değerlendirme dışı bırakılacaktır.

- Envanterdeki puanlar düşükse, katılımcı, her grup için listeden rastgele sayılar üreten bir bilgisayar programı kullanan Rastgele sayı üreteci kullanılarak aşağıdaki gruplara rastgele atanacaktır: iki deney ve iki kontrol grubu, her grup oluşacaktır 15'i kadın olmak üzere toplamda 60 katılımcı olacak.

1. Daha sonra iki gruba ÖN-TEST, PERMA Ölçüm Aracı, Bilişsel Duygu Düzenleme Ölçeği, Algılanan Stres Ölçeği uygulanarak deney grubuna müdahale verilecek, kontrol grubuna ise müdahale yapılmayacaktır.

2. Müdahalenin uygulanmasından sonra her iki gruba da POST-TEST, PERMA Ölçüm Aracı, Bilişsel Duygu Düzenleme Ölçeği, Algılanan Stres Ölçeği uygulanacaktır ve deneyden 2 hafta sonra takip yapılacaktır.

3. Sonunda müdahale kontrol grubuna da uygulanacaktır.

c. Araştırmanın Nedeni: ☐ Bilimsel araştırma ☒ Tez çalışması

d. Araştırma Uygulamasının Öngörülen Süresi (**yaklaşık olarak dakika ve/veya saat)**: 1saat 30 dk ila 2 saat aralığında öngörülmüştür.

e. Araştırmaya Katılması Beklenen Katılımcı/Gönüllü Sayısı: 60 kişidir

f. Araştırmanın Yapılacağı Yer(ler): kadın sığınma evleri, dernekler ve vakıflar, aynı zamanda Adalet Bakanlığı Adli Destek ve Mağdur Hizmetleri Dairesi Başkanlığı ile iletişime geçilecektir.

2. Çalışmaya Katılım Onayı:

Yukarıda yer alan ve araştırmadan önce katılımcıya/gönüllüye verilmesi gereken bilgileri okudum ve katılmam istenen çalışmanın kapsamını ve amacını, gönüllü olarak üzerime düşen sorumlulukları tamamen anladım. **Çalışma hakkında yazılı ve sözlü açıklama aşağıda adı belirtilen araştırmacı tarafından yapıldı, soru sorma ve tartışma imkanı buldum ve tatmin edici yanıtlar aldım. Bana, çalışmanın muhtemel riskleri ve faydaları sözlü olarak da anlatıldı.** Bu çalışmayı istediğim zaman ve herhangi bir neden belirtmek zorunda kalmadan bırakabileceğimi ve bıraktığım takdirde herhangi bir olumsuzluk ile karşılaşmayacağımı anladım.

Bu koşullarda söz konusu araştırmaya kendi isteğimle, hiçbir baskı ve zorlama olmaksızın katılmayı kabul ediyorum.

Katılımcının (Kendi el yazısı ile)
Adı-
Soyadı:.....
İmzası:

(Varsa) Velayet veya Vesayet Altında Bulunanlar İçin;

Veli veya Vasisinin (Kendi el yazısı ile)

Adı-
Soyadı:.....
İmzası:

Not: *Bu form, iki nüsha halinde düzenlenir. Bu nüshalardan biri imza karşılığında gönüllü kişiye verilir, diğeri araştırmacı tarafından saklanır.*

6.2. APPENDIX-2: DEMOGRAPHIC INFORMATION FORM IN THE FIRST AND SECOND STUDY

Demografik Form

I. Katılımcı Bilgileri:

II. Yaş grubu:

A.18-24

B.25-34

C.35-44

Ö.45-54

E.55-64

F.65 ve üzeri

III. Cinsiyet:

A.Erkek

B.Kadın

D. Söylememeyi tercih ederim

E. Diğer (lütfen belirtiniz): _____

IV. Mevcut İlişki Durumu:

A. Bekar

B. Ilişkisi var

C.Evli

D. Ayrılmış

E. Boşanmış

F.Dul

V. Mevcut İlişkinin Süresi:

A. 6 aydan az

B. 6 aydan 1 yıla kadar

C.1-2 yıl

D.2-5 yıl

E.5-10 yıl

F.10+ yıl

VI. Cinsel Yönelim:

A. Heteroseksüel

B. Eşcinsel

C. Biseksüel

D. Panseksüel

E. Diğer (lütfen belirtiniz): _____

VII. Eğitim Seviyesi:

A. Orta Okul Mezunu

B. Lise mezunu

C. Meslek Lisesi Mezunu

D. Lisans derecesi

E. Yüksek lisans derecesi

F. Doktora derecesi

G. Diğer (lütfen belirtin): _____

VIII. Çalışma durumu:

A. Tam zamanlı çalışan

B. Yarı zamanlı çalışan

C. İşsiz

D. Öğrenci

E. Ev kadını

F.Emekli

G. Diğer (lütfen belirtin): _____

IX. Çocuk Sayısı:

A.0

B.1

C.2

D.3

E.4+

F. Söylememeyi tercih ederim

X. Partner Bilgileri:

A. Partnerin Yaşı: _____

B. Partnerin Eğitim Düzeyi: _____

C. Partnerin Çalışma Durumu: _____

XI. Yaşam Durumu:

A. Birlikte yaşıyor

B. Ayrı yaşıyor

6.3. APPENDIX-3: KISA SEMPTOM ENVANTERI-KSE

EK 1. KISA SEMPTOM ENVANTERİ

Aşağıda, insanların bazen yaşadıkları belirtilerin ve yakınmaların bir listesi verilmiştir. Listedeki her maddeyi lütfen dikkatle okuyunuz. Daha sonra, o belirtinin SİZDE BUGÜN DAHİL, SON BİR HAFTADIR NE KADAR VAR OLDUĞUNU yandaki bölmede uygun olan yere işaretleyiniz. Her belirti için sadece bir yeri işaretlemeye ve hiçbir maddeyi atlamamaya özen gösteriniz. Yanıtlarınızı kurşun kalemle işaretleyiniz. Eğer fikir değiştirirseniz ilk yanıtınızı siliniz.

Yanıtlarınızı aşağıdaki ölçeğe göre değerlendiriniz:
Bu belirtiler son bir haftadır sizde ne kadar var?

0. Hiç yok **3. Epey var**
1. Biraz var **4. Çok fazla var**
2. Orta derecede var

	Bu belirtiler son bir haftadır sizde ne kadar var?				
	Hiç				**Çok fazla**
1. İçinizdeki sinirlilik ve titreme hali	0	1	2	3	4
2. Baygınlık, baş dönmesi	0	1	2	3	4
3. Bir başka kişinin sizin düşüncelerinizi kontrol edeceği fikri	0	1	2	3	4
4. Başınıza gelen sıkıntılardan dolayı başkalarının suçlu olduğu duygusu	0	1	2	3	4
5. Olayları hatırlamada güçlük	0	1	2	3	4

	Hiç				Çok fazla
6. Çok kolayca kızıp öfkelenme	0	1	2	3	4
7. Göğüs (kalp) bölgesinde ağrılar	0	1	2	3	4
8. Meydanlık (açık) yerlerden korkma duygusu	0	1	2	3	4
9. Yaşamınıza son verme düşünceleri	0	1	2	3	4
10. İnsanların çoğuna güvenilmeyeceği hissi	0	1	2	3	4
11. İştahta bozukluklar	0	1	2	3	4
12. Hiçbir nedeni olmayan ani korkular	0	1	2	3	4
13. Kontrol edemediğiniz duygu patlamaları	0	1	2	3	4
14. Başka insanlarla beraberken bile yalnızlık hissetmek	0	1	2	3	4
15. İşleri bitirme konusunda kendini engellenmiş hissetmek	0	1	2	3	4
16. Yalnızlık hissetmek	0	1	2	3	4
17. Hüzünlü, kederli hissetmek	0	1	2	3	4
18. Hiçbir şeye ilgi duymamak	0	1	2	3	4
19. Ağlamaklı hissetmek	0	1	2	3	4
20. Kolayca incinebilme, kırılmak	0	1	2	3	4
21. İnsanların sizi sevmediğine, kötü davrandığına inanmak	0	1	2	3	4

	Hiç				Çok fazla
22. Kendini diğerlerinden daha aşağı görme	0	1	2	3	4
23. Mide bozukluğu, bulantı	0	1	2	3	4
24. Diğerlerinin sizi gözlediği ya da hakkınızda konuştuğu duygusu	0	1	2	3	4
25. Uykuya dalmada güçlük	0	1	2	3	4
26. Yaptığınız şeyler tekrar tekrar doğru mu diye kontrol etmek	0	1	2	3	4
27. Karar vermede güçlükler	0	1	2	3	4
28. Otobüs, tren, metro gibi umumi vasıtalarla seyahatlerden korkmak	0	1	2	3	4
29. Nefes darlığı, nefessiz kalmak	0	1	2	3	4
30. Sıcak-soğuk basmaları	0	1	2	3	4
31. Sizi korkuttuğu için bazı eşya, yer yada etkinliklerden uzak kalmaya çalışmak	0	1	2	3	4
32. Kafanızın "bomboş" kalması	0	1	2	3	4
33. Bedeninizin bazı bölgelerinde uyuşmalar, karıncalanmalar	0	1	2	3	4
34. Günahlarınız için cezalandırılmanız gerektiği	0	1	2	3	4
35. Gelecekle ilgili umutsuzluk duyguları	0	1	2	3	4
36. Konsantrasyonda (dikkati bir şey üzerinde toplama) güçlük/zorlanmak	0	1	2	3	4

	Hiç				Çok fazla
37. Bedeninizin bazı bölgelerinde zayıflık, güçsüzlük hissi	0	1	2	3	4
38. Kendini gergin ve tedirgin hissetmek	0	1	2	3	4
39. Ölme ve ölüm üzerine düşünceler	0	1	2	3	4
40. Birini dövme, ona zarar verme, yaralama isteği	0	1	2	3	4
41. Bir şeyleri kırma, dökme isteği	0	1	2	3	4
42. Diğerlerinin yanındayken yanlış bir şeyler yapmamaya çalışmak	0	1	2	3	4
43. Kalabalıklarda rahatsızlık duymak	0	1	2	3	4
44. Bir başka insana hiç yakınlılık duymamak	0	1	2	3	4
45. Dehşet ve panik nöbetleri	0	1	2	3	4
46. Sık sık tartışmaya girmek	0	1	2	3	4
47. Yalnız bırakıldığında/kalındığında sinirli hissetmek	0	1	2	3	4
48. Başarılarınız için diğerlerinden yeterince takdir görmemek	0	1	2	3	4
49. Yerinde duramayacak kadar kendini tedirgin hissetmek	0	1	2	3	4
50. Kendini değersiz görmek	0	1	2	3	4
51. Eğer izin verirseniz insanların sizi sömüreceği duygusu	0	1	2	3	4

	Hiç				Çok fazla
52. Suçluluk duyguları	0	1	2	3	4
53. Aklınızda bir bozukluk olduğu fikri	0	1	2	3	4

6.4. APPENDIX-4: COGNITIVE EMOTION REGULATION QUESTIONNAIRE (CERQ)

Bilişsel Duygu Düzenleme Ölçeği

BAŞIMA KÖTÜ BİR OLAY GELDİĞİNDE		Hiç	Nadiren	Ara sıra	Sıklıkla	Her zaman
	1) Bunun suçlusu benim diye düşünürüm.	( )	( )	( )	( )	( )
	2) Artık bu olayın olup bittiğini kabul etmek zorunda olduğumu düşünürüm.	( )	( )	( )	( )	( )
	3) Bu yaşadığımla ilgili ne hissettiğimi düşünürüm.	( )	( )	( )	( )	( )
	4)Yaşadıklarımdan daha hoş olan şeyleri düşünürüm.	( )	( )	( )	( )	( )
	5) Yapabileceğim en iyi şeyi düşünürüm.	( )	( )	( )	( )	( )
	6) Bu olaydan bir şeyler öğrenebileceğimi düşünürüm.	( )	( )	( )	( )	( )
	7) Her şey çok daha kötü olabilirdi diye düşünürüm.	( )	( )	( )	( )	( )
	8) Yaşadığım olayın başkalarının başına gelenlerden daha kötü olduğunu düşünürüm.	( )	( )	( )	( )	( )
	9) Bu olayda başkalarının suçu olduğunu düşünürüm.	( )	( )	( )	( )	( )
	10) Bu olayın tek sorumlusunun ben olduğumu düşünürüm.	( )	( )	( )	( )	( )

		Hiç	Nadiren	Ara sıra	Sıklıkla	Her zaman
	11) Durumu kabullenmek zorunda olduğumu düşünürüm.	( )	( )	( )	( )	( )
	12) Zihnim yaşadığım olay hakkında ne düşündüğüm ve hissettiğimle sürekli meşgul olur.	( )	( )	( )	( )	( )
	13) Olayla hiç ilgisi olmayan hoş şeyler düşünürüm.	( )	( )	( )	( )	( )
	14) Bu durumla en iyi nasıl başa çıkabileceğimi düşünürüm.	( )	( )	( )	( )	( )
	15) Başımdan geçenlerin bir sonucu olarak daha güçlü bir insan haline gelebileceğimi düşünürüm.	( )	( )	( )	( )	( )
	16) Diğer insanların çok daha kötü tecrübeler geçirdiklerini düşünürüm.	( )	( )	( )	( )	( )
	17) Başıma gelen olayın ne kadar korkunç olduğunu düşünüp dururum.	( )	( )	( )	( )	( )
	18) Başımdan geçen olaydan başkalarının sorumlu olduğunu düşünürüm.	( )	( )	( )	( )	( )
	19) Bu olayda yaptığım hataları düşünürüm.	( )	( )	( )	( )	( )
	20) Bu olayla ilgili hiçbir şeyi değiştiremeyeceğimi düşünürüm.	( )	( )	( )	( )	( )
	21) Bu olayla ilgili neden böyle hissettiğimi anlamak isterim.	( )	( )	( )	( )	( )
	22) Başımdan geçen olay yerine hoş bir şeyler düşünürüm.	( )	( )	( )	( )	( )
	23) Bu durumu nasıl değiştireceğimi düşünürüm.	( )	( )	( )	( )	( )

		Hiç	Nadiren	Ara sıra	Sıklıkla	Her zaman
	24) Bu durumun olumlu yanlarının da olduğunu düşünürüm.	( )	( )	( )	( )	( )
	25)Diğer şeylerle karşılaştırıldığında bunun o kadar da kötü olmadığını düşünürüm.	( )	( )	( )	( )	( )
	26) Yaşadığım bu şeyin bir insanın başına gelebilecek en kötü şey olduğunu düşünürüm.	( )	( )	( )	( )	( )
	27) Bu olayda diğerlerinin yaptığı hataları düşünürüm.	( )	( )	( )	( )	( )
	28) Esas sebebin kendimle ilgili olduğunu düşünürüm.	( )	( )	( )	( )	( )
	29) Bununla yaşamayı öğrenmem gerektiğini düşünürüm.	( )	( )	( )	( )	( )
	30) Bu durumun bende uyandırdığı duygularla boğuşurum.	( )	( )	( )	( )	( )
	31) Hoş olayları düşünürüm.	( )	( )	( )	( )	( )
	32) Yapabileceğim en iyi şeyle ilgili bir plan düşünürüm.	( )	( )	( )	( )	( )
	33) Bu durumun olumlu yanlarını ararım.	( )	( )	( )	( )	( )
	34) Kendime hayatta daha kötü şeylerin de olduğunu söylerim.	( )	( )	( )	( )	( )
	35) Sürekli bu durumun ne kadar korkunç olduğunu düşünürüm.	( )	( )	( )	( )	( )
	36) Esas sebebin başkalarıyla ilgili olduğunu düşünürüm.	( )	( )	( )	( )	( )

6.5. APPENDIX-5: PERMA ÖLÇME ARACI

Ek 1: PERMA Ölçme Aracı

Lütfen aşağıdaki ifadeleri okuduktan sonra **0 ile 10** arasında size en uygun olan seçeneğin üzerine çarpı (X) işareti koyunuz.	
1	Genel olarak, ne ölçüde amaçlı ve anlamlı bir hayat sürdürmektesiniz? Hiç 0 1 2 3 4 5 6 7 8 9 10 Tamamen
2	Ne sıklıkla hedeflerinize ulaşmak için ilerleme kaydettiğinizi hissedersiniz? Hiçbir zaman 0 1 2 3 4 5 6 7 8 9 10 Her zaman
3	Ne sıklıkla yaptığınız işe kendinizi verirsiniz? Hiçbir zaman 0 1 2 3 4 5 6 7 8 9 10 Her zaman
4	Genel olarak, sağlık durumunuz nasıl? Çok Kötü 0 1 2 3 4 5 6 7 8 9 10 Mükemmel
5	Genel olarak, ne sıklıkta neşeli hissedersiniz? Hiçbir zaman 0 1 2 3 4 5 6 7 8 9 10 Her zaman
6	İhtiyacınız olduğunda ne ölçüde başkalarından yardım ve destek alabilirsiniz? Hiç 0 1 2 3 4 5 6 7 8 9 10 Tamamen
7	Genel olarak, ne sıklıkta endişeli hissedersiniz? Hiçbir zaman 0 1 2 3 4 5 6 7 8 9 10 Her zaman
8	Kendiniz için belirlediğiniz önemli hedeflere ne sıklıkla ulaşırsınız? Hiçbir zaman 0 1 2 3 4 5 6 7 8 9 10 Her zaman
9	Genel olarak, hayatınızda yaptıklarınızın ne ölçüde değerli ve faydalı olduğunu hissedersiniz? Hiç 0 1 2 3 4 5 6 7 8 9 10 Tamamen
10	Genel olarak, ne sıklıkta olumlu hissedersiniz? Hiçbir zaman 0 1 2 3 4 5 6 7 8 9 10 Her zaman
11	Genel olarak, ne ölçüde olaylara karşı heyecanlı ve ilgili hissedersiniz? Hiç 0 1 2 3 4 5 6 7 8 9 10 Tamamen
12	Günlük yaşamınızda kendinizi ne kadar yalnız hissedersiniz? Hiç 0 1 2 3 4 5 6 7 8 9 10 Tamamen
13	Mevcut fiziksel sağlık durumunuzdan ne kadar memnunsunuz? Hiç 0 1 2 3 4 5 6 7 8 9 10 Tamamen
14	Genel olarak, ne sıklıkta öfkeli hissedersiniz? Hiçbir zaman 0 1 2 3 4 5 6 7 8 9 10 Her zaman
15	Ne derecede sevildiğinizi hissedersiniz? Hiç 0 1 2 3 4 5 6 7 8 9 10 Tamamen
16	Sorumluluklarınızı ne sıklıkla yerine getirebilirsiniz? Hiçbir zaman 0 1 2 3 4 5 6 7 8 9 10 Her zaman
17	Genel olarak, ne ölçüde hayatınızın bir yönü olduğunu hissedersiniz? Hiç 0 1 2 3 4 5 6 7 8 9 10 Tamamen
18	Kendinizi sizinle aynı yaş ve cinsiyet grubuyla karşılaştırdığınızda sağlık durumunuz nasıl? Çok Kötü 0 1 2 3 4 5 6 7 8 9 10 Mükemmel
19	Kişisel ilişkilerinizden ne kadar memnunsunuz? Hiç 0 1 2 3 4 5 6 7 8 9 10 Tamamen
20	Genel olarak ne sıklıkla üzgün hissedersiniz? Hiç 0 1 2 3 4 5 6 7 8 9 10 Tamamen
21	Ne sıklıkla eğlenceli bir şeyler yaparken zamanın nasıl geçtiğini anlamazsınız? Hiçbir zaman 0 1 2 3 4 5 6 7 8 9 10 Her zaman
22	Genel olarak ne ölçüde memnun hissedersiniz? Hiç 0 1 2 3 4 5 6 7 8 9 10 Tamamen
23	Her şeyi birlikte değerlendirdiğinizde ne kadar mutlusunuz? Hiç 0 1 2 3 4 5 6 7 8 9 10 Tamamen

6.6. APPENDIX-6: ÇOK BOYUTLU DUYGUSAL İSTISMAR ÖLÇEĞI (ÇBDİÖ)

Çok Boyutlu Duygusal İstismar Ölçeği (ÇBDİÖ)

Aşağıda, partnerinizle ilişkinizdeki <u>son altı ayı</u> düşünerek yanıtlamanız istenen maddeler verilmiştir. Şu anda bir partneriniz yoksa bu maddeleri bir önceki ilişkinizi düşünerek yanıtlayabilirsiniz. Her bir madde için iki yanıt vermeniz gerekmektedir. "Siz" yazan satırda, belirtilen davranışı sizin ne sıklıkta yaptığınızı gösteren rakamı daire içine alarak işaretleyiniz. "Partneriniz" yazan satırda ise belirtilen davranışı, partnerinizin ne sıklıkta yaptığını gösteren rakamı daire içine alarak işaretleyiniz. Eğer siz ya da partneriniz bu davranışlardan birini son altı ay içinde göstermediyseniz ama daha önceden yaptıysanız 7'yi işaretleyiniz.

(1) Bir kere *(4) 6-10 kere* *(7) Son altı ayda olmadı ama daha önce oldu*
(2) İki kere *(5) 11-20 kere* *(0) Hiçbir zaman olmadı*
(3) 3-5 kere *(6) 20 kereden fazla*

	Bir kere	İki kere	3-5 kere	6-10 kere	11-20 kere	20 + kere	Son 6 ayda olmadı	Hiç olmadı
1.Partnerime şüpheci bir tavırla nerede veya kimlerle birlikte olduğunu sordum.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**0**
2.Partnerim bana şüpheci bir tavırla nerede veya kimlerle birlikte olduğunu sordu.								
3.Partnerimin kişisel eşyalarını gizlice karıştırdım.								
4.Partnerim kişisel eşyalarımı gizlice karıştırdı.								
5.Partnerimin bazı arkadaşları veya aile üyeleriyle görüşmesini engellemeye çalıştım.								
6.Partnerim bazı arkadaşlarım veya aile üyelerimle görüşmemi engellemeye çalıştı.								
7.Partnerimin, arkadaşları ile çok fazla zaman geçirmesinden şikayet ettim.								
8.Partnerim, arkadaşlarım ile çok fazla zaman geçirmemden şikayet etti.								
9.Partnerime, bana haber vermeden bir yere gittiği için kızdım.								
10.Partnerim, ona haber vermeden bir yere gittiğim için kızdı.								
11.Partnerimi birlikte yeterince vakit geçiremediğimiz için suçlu hissettirmeye çalıştım.								
12.Partnerim beni birlikte yeterince vakit geçiremediğimiz için suçlu hissettirmeye çalıştı.								
13.Partnerimin nerede veya kimlerle birlikte olduğunu arkadaşlarına veya akrabalarına sorarak kontrol ettim.								
14.Partnerim nerede veya kimlerle birlikte olduğumu arkadaşlarıma veya akrabalarıma sorarak kontrol etti.								
15.Partnerimin aptal olduğunu söyledim ya da ima ettim.								

16. Partnerim benim aptal olduğunu söyledi ya da ima etti.								
17. Partnerime onun değersiz olduğunu söyledim.								
18. Partnerim bana değersiz olduğunu söyledi.								
19. Partnerime çirkin olduğunu söyledim.								
20. Partnerim bana çirkin olduğunu söyledi.								
21. Partnerimin dış görünüşünü eleştirdim.								
22. Partnerim benim dış görünüşümü eleştirdi.								
23. Partnerime zavallı, başarısız ya da benzeri bir ifade ile hitap ettim.								
24. Partnerim bana zavallı, başarısız ya da benzeri bir ifade ile hitap etti.								
25. Partnerimi diğer insanların önünde küçük düşürdüm.								
26. Partnerim beni diğer insanların önünde küçük düşürdü.								
27. Partnerime bir başka kişinin ondan daha iyi bir eş/sevgili olacağını söyledim.								
28. Partnerim bana bir başka kişinin benden daha iyi bir eş/sevgili olacağını söyledi.								
29. Konuşamayacak ya da konuşmayı istemeyecek kadar sinirlendim.								
30. Partnerim konuşamayacak ya da konuşmayı istemeyecek kadar sinirlendi.								
31.Kızdığımda partnerime soğuk ya da mesafeli davrandım.								
32.Kızdığında partnerim bana karşı soğuk ya da mesafeli davrandı.								
33. Bir sorun hakkında herhangi bir tartışma yapmayı reddettim.								
34. Partnerim bir sorun hakkında herhangi bir tartışma yapmayı reddetti.								
35. Partnerim bir sorun hakkında tartışmaya çalışırken kasıtlı olarak konuyu değiştirdim.								
36. Ben bir sorun hakkında tartışmaya çalışırken partnerim kasıtlı olarak konuyu değiştirdi.								
37. Partnerim için önemli olan bir sorunun varlığını reddettim.								
38. Partnerim benim için önemli olan bir sorunun varlığını reddetti.								
39. Bir konu hakkında konuşmayı reddettim ya da surat astım/küstüm.								
40. Partnerim bir konu hakkında konuşmayı reddetti ya da surat astı/küstü.								
41. Bir çatışma ya da anlaşmazlık anında kasıtlı olarak partnerimden uzak durdum.								
42. Bir çatışma ya da anlaşmazlık anında kasıtlı olarak partnerim benden uzak durdu.								

43.Partnerimi korkutacak kadar öfkelendim.								
44.Partnerim beni korkutacak kadar öfkelendi.								
45.Partnerime fikirlerimi saldırganca diretmeye çalıştım.								
46. Partnerim bana fikirlerini saldırganca diretmeye çalıştı.								
47.Partnerimi vurmakla/dövmekle tehdit ettim.								
48.Partnerim beni vurmakla/dövmekle tehdit etti.								
49.Partnerimi bir şey fırlatmakla tehdit ettim.								
50.Partnerim beni bir şey fırlatmakla tehdit etti.								
51.Partnerimin önünde bir şeyler fırlattım, bir şeyleri kırıp döktüm, tekmeledim ya da bir şeylere vurdum.								
52.Partnerim benim önümde bir şeyler fırlattı, bir şeyleri kırıp döktü, tekmeledi ya da bir şeylere vurdu.								
53.Partnerimi korkutmak için tehlikeli bir şekilde araba kullandım.								
54.Partnerim beni korkutmak için tehlikeli bir şekilde araba kullandı.								
55.Bir çatışma ya da anlaşmazlık anında partnerimin tepesinde dikildim veya etrafında dolanıp durdum.								
56.Bir çatışma ya da anlaşmazlık anında partnerim tepemde dikildi veya etrafımda dolanıp durdu.								

6.7. APPENDIX-7: PERCEIVED STRESS SCALE (PSS)

Algılanan Stres Ölçeği

Yönerge: Aşağıda geçtiğimiz ay içerisindeki kişisel deneyimleriniz hakkında bir dizi soru yöneltilmektedir. Her soruyu dikkatlice okuyarak size en uygun seçeneğin altındaki kutuya bir çarpı işareti koyarak cevaplayınız. Soruların doğru veya yanlış cevabı yoktur. Önemli olan sizin duygu ve düşüncelerinizi yansıtan yanıtları vermenizdir.

	Hiçbir Zaman	Neredeyse Hiçbir Zaman	Bazen	Oldukça Sık	Çok sık
1. Geçen ay, beklenmedik bir şeylerin olması nedeniyle ne sıklıkta rahatsızlık duydunuz?					
2. Geçen ay, hayatınızdaki önemli şeyleri kontrol edemediğinizi ne sıklıkta hissettiniz?					
3. Geçen ay, kendinizi ne sıklıkta sinirli ve stresli hissettiniz?					
4. Geçen ay, ne sıklıkta gündelik zorlukların üstesinden başarıyla geldiniz?					
5. Geçen ay, hayatınızda ortaya çıkan önemli değişikliklerle etkili bir şekilde başa çıktığınızı ne sıklıkta hissettiniz?					
6. Geçen ay, kişisel sorunlarınızı ele alma yeteneğinize ne sıklıkta güven duydunuz?					
7. Geçen ay, her şeyin yolunda gittiğini ne sıklıkta hissettiniz?					
8. Geçen ay, ne sıklıkta yapmanız gereken şeylerle başa çıkamadığınızı fark ettiniz?					
9. Geçen ay, hayatınızdaki zorlukları ne sıklıkta kontrol edebildiniz?					
10. Geçen ay, ne sıklıkta her şeyin üstesinden geldiğinizi hissettiniz?					
11. Geçen ay, ne sıklıkta kontrolünüz dışında gelişen olaylar yüzünden öfkelendiniz?					
12. Geçen ay, kendinizi ne sıklıkta başarmak zorunda olduğunuz şeyleri düşünürken buldunuz?					
13. Geçen ay, ne sıklıkta zamanınızı nasıl kullanacağınızı kontrol edebildiniz?					
14. Geçen ay, ne sıklıkta problemlerin üstesinden gelemeyeceğiniz kadar biriktiğini hissettiniz?					

6.8. APPENDIX-8: INTERVENTION IN THE SECOND STUDY

Emotional Abuse Intervention Program: Facilitator Manual

Program Overview

Purpose:

This nine-session, evidence-based intervention supports individuals recovering from emotional abuse by improving emotional regulation, reducing stress, and rebuilding psychological well-being. It integrates techniques from Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT).

Structure:

- 9 Weekly Sessions, 90 minutes each
- Closed group format to ensure continuity and psychological safety

Assessment Tools:

- Multidimensional Measure of Emotional Abuse (MMEA)
- PERMA Well-Being Scale
- Cognitive Emotion Regulation Questionnaire (CERQ)
- Perceived Stress Scale (PSS)

Assessment Timeline:

- Week 1 (Pre-test)
- Post-intervention (Week 9)
- Follow-up (3 weeks post-intervention)

Session 1: Introduction to the Program

Session Objectives

1. Build trust, cohesion, and a sense of safety.
2. Introduce the program structure, goals, and expectations.
3. Establish group norms around respect and confidentiality.
4. Begin psychoeducation on emotional abuse.

Duration: 90 minutes

Facilitator Preparation

- Print copies of group norms and consent forms.
- Prepare materials for icebreaker activities and prizes.
- Have a whiteboard or flip chart available to note participant expectations and program goals.

Session Outline

1. Welcome and Program Overview (10 minutes)

Script:

"Welcome, and thank you for being here. This program is a space where healing can begin—through shared experience, evidence-based tools, and mutual support. You are not alone. Over the next 9 weeks, we'll focus on reducing stress, improving your emotional regulation, and rebuilding your sense of self-worth."

"We will be using techniques from CBT and ACT, both of which are highly effective for recovery from emotional trauma. Attendance is key, and since this is a closed group, we ask that participants commit to consistent presence with only one excused absence."

2. Participant Introductions (20 minutes)

Instructions:

- Invite each participant to share their name, age (optional), location, and anything they're comfortable disclosing.
- Review group norms: respect, confidentiality, non-judgment, and support.

Script:

"Everything shared in this room stays in this room—unless someone is in danger or at risk of harm. We're here to support one another without judgment."

3. Icebreakers (20 minutes)

Activity 1: "10 Things in Common" (10 min)

- Participants pair up and discover 10 unique things in common—excluding generic items like "we both like music."
- Share findings with the group. Award a small prize for creativity.

Activity 2: "Speed Networking" (10 min)

- Rotate participants through 3-minute conversations.
- Provide prompts (e.g., "What's a hobby you enjoy?" "What's something you've done this week for yourself?")

4. Group Expectations & Program Goals (15 minutes)

Prompt Questions:

- “What do you hope to gain from this program?”
- “What support do you need to feel safe here?”

Facilitator Task:

- Record responses visibly. Reflect back shared hopes to validate.
- Present the program’s three core goals:
    - Reduce perceived stress
    - Improve emotional regulation
    - Enhance psychological well-being

Participant Quotes (examples to share if needed):

“I want to stop blaming myself for things I couldn’t control.”

“I’m hoping to rebuild my confidence and learn how to set boundaries.”

5. Program Structure and Assessments (10 minutes)

Script:

“We’ll meet weekly for 90 minutes over 9 sessions. Assessments will be completed now, at the end, and three weeks after. These help us measure growth and adjust our future programming.”

Reiterate:

- Group is closed.
- Confidentiality is crucial.
- One excused absence is allowed.

6. Introduction to Emotional Abuse (15 minutes)

Definition (Provide handout or visual):

"Emotional abuse includes manipulation, gaslighting, isolation, and criticism intended to erode your self-worth."

Examples (read aloud or ask for input):

- Gaslighting: "That never happened. You're imagining it."
- Control: "Give me your passwords—if you've got nothing to hide, it shouldn't matter."
- Isolation: "Your friends don't care about you like I do."

Discussion Questions:

- "Have you ever felt confused about whether what you experienced was abuse?"
- "How has emotional abuse impacted your ability to trust or regulate emotion?"

7. Conclusion (5 minutes)

Key Reminders:

- Review group norms again.
- Share date and time for Session 2.
- Emphasize confidentiality and emotional safety.

Closing Script:

"Thank you for your courage and honesty today. This group is here for healing, and your presence is part of that healing. I look forward to seeing you next week."

Homework Assignment

1. Reflect on: “What does emotional abuse mean to me?” Write freely.
2. Take one self-care action this week. Be prepared to share next session.

Materials Needed

- Group norms handouts
- Icebreaker instructions
- Markers, pens, name tags
- Printed schedule overview
- Journals or worksheets for reflection

Facilitator Tips

- Validate all participant input.
- Watch for signs of discomfort and check in.
- Use trauma-informed language.
- Normalize difficult emotions.

Participant Handouts

- Program Overview
- Confidentiality Agreement
- Group Norms

- Emotional Abuse Definitions (with examples)
- Weekly Reflection Journal Template

Session 2: Psychoeducation on Emotional Abuse

Session Objectives

1. Provide psychoeducation about emotional abuse, its impact, and the recovery process.
2. Introduce the body's stress response and how emotional abuse impairs emotional regulation.
3. Present foundational techniques from ACT (Acceptance and Commitment Therapy) and CBT (Cognitive Behavioral Therapy).
4. Support participants in understanding and beginning to use coping strategies.

Duration: 90 minutes

Facilitator Preparation

- Print or prepare handouts with definitions of emotional abuse and ACT/CBT tools.
- Set up for mindfulness exercise ("Observing Thoughts as Clouds").
- Prepare prompts and whiteboard or flip chart for discussion notes.

Session Structure

1. Icebreaker: Emotional Check-In (5 minutes)

Prompt participants to share:

- One word that reflects how they're feeling today.

- One reflection or insight from last week's homework (self-care or emotional abuse journaling).

Example reflections:

- *"Hopeful" – Journaling made me feel heard, even just by myself.*
- *"Anxious" – It's hard to admit how deep the abuse affected me.*
- *"Relieved" – I feel less alone hearing others' stories.*

2. Review of Previous Session (5 minutes)

- Revisit definitions of emotional abuse and its psychological effects.
- Reinforce the importance of self-awareness and self-care.

Facilitator Prompt:

"What did you notice after reflecting on your experience of emotional abuse? What did your self-care look like this week?"

Examples:

- *"I took a long walk and allowed myself to just feel."*
- *"I practiced saying no and felt guilty—but also strong."*

3. Understanding Emotional Abuse (10 minutes)

Definition Recap:

Emotional abuse is the use of non-physical tactics—such as gaslighting, isolation, criticism, control, and manipulation—to undermine someone's self-worth and autonomy.

Facilitator shares or asks for examples:

- *Gaslighting:* "I never said that—you're imagining things."
- *Criticism:* "You always mess things up."
- *Isolation:* "Your friends are toxic, you should stop seeing them."
- *Control:* "If you loved me, you'd show me your messages."

Discussion Prompt:

"Which of these patterns feels familiar to you? What were the emotional consequences?"

4. Stress and Emotional Regulation Deficits (10 minutes)

Key Teaching Points:

- Emotional abuse activates the fight/flight/freeze stress response long-term.
- This can result in emotional overreactions, shutdown, or avoidance.

Script:

"Survivors of emotional abuse often feel like their bodies are always 'on alert.' That chronic stress can make it harder to trust, relax, or regulate emotions."

Examples from participants:

- *"I overreacted to a text delay—it triggered my fear of being ignored."*
- *"Criticism, even if kind, makes me panic."*
- *"Sometimes I feel numb—it's like I don't want to feel anything anymore."*

5. Introduction to ACT and CBT Principles (20 minutes)

ACT (Acceptance and Commitment Therapy):

- Acceptance: Let uncomfortable emotions exist without fighting them.
- Defusion: See thoughts as passing experiences, not facts.
- Mindfulness: Stay present to reduce emotional overwhelm.

Mindfulness Activity: "Observing Thoughts as Clouds" (5–7 minutes)

- Guide participants to imagine their thoughts floating by as clouds.
- Emphasize non-judgmental observation.
- Invite brief reflection afterward.

Reflection Prompt:

"What was it like to observe your thoughts without reacting to them?"

Common responses:

- *"I noticed how fast they come and go."*
- *"It was hard not to get pulled in, but it felt calming."*

CBT (Cognitive Behavioral Therapy):

- Identify and challenge automatic negative thoughts.
- Replace distorted thinking with balanced alternatives.

CBT Exercise: Thought Reframing

- Provide examples and practice together:

- *"I'm broken." → "I've been hurt, but I'm healing."*
- *"I can't do anything right." → "I make mistakes, and I learn from them."*

Discussion Prompt:

"How do your thoughts affect how you feel and act?"

6. Coping Strategies for Healing (15 minutes)

Key Concepts:

- Use mindfulness to ground yourself in moments of distress.
- Reframe self-critical thoughts with compassion.
- Accept, name, and sit with emotions instead of avoiding them.

Participant Examples:

- *"I paused and named my emotion: 'This is sadness,' and that helped me not spiral."*
- *"I practiced breathing when I felt overwhelmed."*

7. Closing Summary and Grounding (5 minutes)

Review Key Takeaways:

- Emotional abuse causes long-term stress and emotional dysregulation.
- Mindfulness and thought reframing can reduce that reactivity.
- You can build distance from painful thoughts using defusion.

Grounding Exercise (2 minutes):

“Let’s close by noticing our breath: Inhale for 4… hold… exhale for 6. Feel your feet on the floor. Notice the present moment.”

8. Group Reflection (10 minutes)

Prompts:

- “What insight stood out to you today?”
- “What’s one thing you want to try practicing this week?”

Example Responses:

- *“Mindfulness makes me feel calmer—I want to try it daily.”*
- *“I want to reframe the thought ‘I’m too sensitive’ next time it comes up.”*

Homework Assignment

1. Practice a 5–10 minute mindfulness or breathing exercise each day.
2. Reflect on one moment where you felt emotionally dysregulated. What triggered it? What did you feel? Try applying ACT or CBT techniques.

Session 3: Mindfulness & Acceptance of Emotional Pain (ACT Focus)

Session Objectives

1. Teach participants mindfulness and emotional acceptance techniques to reduce reactivity and perceived stress.

2. Help participants develop emotional regulation skills by reducing avoidance and increasing present-moment awareness.
3. Normalize emotional pain and encourage a compassionate relationship with inner experiences.

Duration: 90 minutes

Facilitator Preparation

- Prepare script for mindfulness and body scan exercises.
- Provide handouts on emotional acceptance and ACT metaphors.
- Set up a calming, distraction-free space for meditation practices.

Session Structure

1. Icebreaker: Emotional Check-In (5 minutes)

Prompt:

"Share one word that describes how you're feeling today."

"Did anything shift for you after practicing mindfulness or reframing your thoughts last week?"

Example Responses:

- *"Grounded – I practiced deep breathing before a tough conversation."*
- *"Tense – I noticed how hard it is to sit with my emotions, but I tried."*
- *"Proud – I recognized a negative thought and didn't let it define me."*

2. Review of Previous Session and Homework (5 minutes)

Prompt:

"What did you learn about your emotional responses this week?"

"Did any techniques from ACT or CBT help during a stressful moment?"

Example Reflections:

- *"Mindfulness gave me a pause before reacting."*
- *"Naming my emotions helped me feel less overwhelmed."*
- *"The 'clouds in the sky' visualization made it easier to let go of racing thoughts."*

3. Introduction to Mindfulness and Acceptance (15 minutes)

Core Concepts:

- Mindfulness is non-judgmental awareness of the present moment.

"It allows us to observe thoughts and feelings without being consumed by them."

- Acceptance means allowing emotions to exist without trying to escape or suppress them.

"You can make space for sadness, anger, guilt—even when they're uncomfortable."

Examples:

- Mindfulness: *"While sipping tea, I focused on its warmth instead of my phone."*
- Acceptance: *"I told myself, 'This is anxiety. I can feel it and still move forward.'"*

Discussion Prompt:

"What would it mean to let your emotions exist without resisting them?"

4. Mindful Breathing Exercise (10 minutes)

Instructions:

- Guide a 5–7 minute breath-focused mindfulness session.
- Encourage participants to gently return their attention to their breath when distracted.

Script Highlights:

"Breathe in through your nose… and slowly exhale through your mouth."

"If your mind wanders, that's okay. Gently bring it back to your breath."

"Each inhale and exhale is an anchor to the present moment."

Post-Exercise Reflection:

- *"I noticed how shallow my breath becomes when I'm anxious."*
- *"I felt calmer just by focusing on one thing."*

5. Body Scan for Emotional Awareness (15 minutes)

Instructions:

- Lead participants through a body scan, focusing awareness from toes to head.
- Invite noticing without judgment—whether they feel tension, warmth, pain, or nothing at all.

Script Highlights:

"Notice the sensations in your feet… your legs… your back and shoulders."

"Is there tightness? Numbness? Energy? Just observe what's there."

Participant Reflections:

- *"I didn't realize I was clenching my jaw the whole time."*
- *"I felt a sense of sadness in my chest, and it made sense."*
- *"I usually avoid body awareness, but this felt grounding."*

6. Acceptance of Difficult Emotions (20 minutes)

Core Teaching:

- Emotional pain is natural. Avoidance amplifies suffering.
- Acceptance gives us room to respond instead of react.

Facilitator Script:

"Avoiding anger, sadness, or fear may seem protective—but it keeps us stuck."

"By sitting with discomfort, we reduce its power over us."

Guided Acceptance Practice:

1. Identify one current emotion.
2. Label it silently (e.g., "This is shame.").
3. Notice where it resides in the body.
4. Sit with it, allowing it to be present without trying to fix or analyze it.

Sample Participant Responses:

- *"I felt guilt in my stomach—tight and heavy—but it eased when I acknowledged it."*
- *"Saying 'this is fear' helped me stop fighting it."*

Reflection Prompt:

“What did it feel like to allow your emotion instead of pushing it away?”

7. Defusion from Stressful Thoughts (15 minutes)

Goal:

Help participants observe thoughts without being entangled in them.

Exercise: Leaves on a Stream (or Clouds in the Sky):

- Guide a visualization where each thought is placed on a leaf/cloud and watched as it floats away.

Instructions:

“Notice a thought… place it on a leaf… and let it drift downstream.”

“If it returns, that’s okay—place it again.”

Participant Reflections:

- *“It made my inner critic seem less powerful.”*
- *“I noticed how many thoughts pass through that aren’t even true.”*

Discussion Prompt:

“What would change if you saw your thoughts as temporary and separate from who you are?”

8. Closing Summary and Grounding (5 minutes)

Key Takeaways:

- Mindfulness and acceptance reduce emotional overwhelm.
- Emotions and thoughts don’t need to be avoided to be managed.

- You can choose how to relate to inner experiences.

Closing Grounding Script (2–3 min):

"Focus on your breath. Feel your feet on the ground. Bring your awareness back to this space. Take a moment to thank yourself for showing up."

Group Reflection and Sharing (10 minutes)

Prompt Questions:

- "Which exercise today was most impactful for you?"
- "How did it feel to sit with your emotions?"
- "What do you want to continue practicing this week?"

Examples of Responses:

- *"The body scan helped me reconnect to myself."*
- *"I want to use the thought defusion practice when I feel overwhelmed."*
- *"It's freeing to know I don't have to fix every emotion—just allow it."*

Homework Assignment

1. Mindfulness Practice:

   Practice mindful breathing or a body scan for 5–10 minutes daily. Note what emotions or thoughts arise.

2. Acceptance Practice:

   When a difficult emotion arises this week, name it and notice where it lives in your body. Let it be present without judgment.

3. Defusion Technique:

   Try the "Leaves on a Stream" exercise when a recurring negative thought arises. Journal what happens before, during, and after.

Session 4: Values Clarification & Committed Action (ACT Focus)

Session Objectives

1. Help participants clarify their personal values to support emotional regulation and a meaningful life.
2. Explore how emotional abuse disconnects individuals from their values.
3. Guide participants in identifying small, value-driven actions (committed action).
4. Build a foundation for long-term behavioral change based on what matters most.

Duration: 90 minutes

Facilitator Preparation

- Prepare values list or worksheet organized by life domains (e.g., health, relationships, growth).
- Have journaling supplies available.
- Create space for reflection and sharing.

Session Structure

1. Icebreaker: Emotional Check-In (5 minutes)

Prompt:

"What's one word to describe how you're arriving in this session?"

"What was it like to practice mindfulness or acceptance over the past week?"

"Did anything shift for you after allowing difficult emotions or using defusion?"

Example Responses:

- *"Present – Mindfulness helped me ground myself when I got overwhelmed."*
- *"Anxious – I noticed I still resist certain emotions, but now I recognize them."*
- *"Hopeful – Accepting sadness actually made it feel less heavy."*

2. Review of Previous Session and Homework (5 minutes)

Prompt:

"Who'd like to share their experience with mindfulness, body scan, or defusion this week?"

"What emotion did you practice accepting, and how did it feel?"

Example Reflections:

- *"I named the feeling of guilt during a conflict and just sat with it—it passed."*
- *"The thought 'I'm not enough' came back, but I placed it on a cloud and let it go."*

3. Introduction to Values Clarification (10 minutes)

Key Concepts:

- Values are ongoing qualities of action—not goals, but guiding directions.

E.g., *"Being a loving parent" is a value. "Calling my child this week" is a goal aligned with that value.*

- Goals are milestones; values are what give our lives meaning.
- Emotional abuse often disconnects people from their values due to shame, fear, or control.

Facilitator Script:

"Many survivors of emotional abuse lose sight of what truly matters to them—what they stand for. Today we reconnect with those deeper parts of you that abuse tried to silence."

4. Values Exploration Exercise (20 minutes)

Step 1: Life Domains

Ask participants to reflect on these areas:

- Relationships
- Health & Self-care
- Work or Meaningful Activity
- Personal Growth
- Leisure or Creativity
- Spirituality or Purpose

Step 2: Guided Prompts

“In each domain, ask yourself: What really matters to me here? What kind of person do I want to be in this area of life?”

Step 3: Worksheet or Discussion

Provide a list of values (e.g., honesty, compassion, independence, growth, creativity, connection). Ask participants to circle 3–5 that resonate most in each life domain.

Examples:

- *“In relationships, I value trust and honesty, but I’ve been afraid to speak up.”*
- *“I used to love art—it gave me joy. I want creativity back in my life.”*

5. Impact of Emotional Abuse on Values (10 minutes)

Discussion Prompt:

“How has emotional abuse affected your ability to live by your values?”

Examples:

- *“I value independence, but I stayed in a controlling relationship.”*
- *“I value kindness, but I ignore my own needs to avoid conflict.”*

Facilitator Notes:

- Normalize that abuse distorts self-perception and decisions.
- Emphasize that values can be reclaimed—starting now.

6. Committed Action: Acting on Values (20 minutes)

Definition:

Committed action means taking small, doable steps that reflect our values—even when emotions like fear or guilt are present.

Prompt:

"Choose one value you circled earlier. What's one small step you can take this week to live that value out loud?"

Examples of Committed Actions:

- Value: *Connection* → "Text a friend and ask how they're doing."
- Value: *Creativity* → "Spend 30 minutes painting or writing."
- Value: *Health* → "Walk outside for 15 minutes today."
- Value: *Courage* → "Practice saying no to something that doesn't align with my needs."

Group Sharing:

Invite volunteers to share one value and their chosen action. Offer encouragement.

7. Overcoming Barriers to Action (10 minutes)

Prompt:

"What thoughts or feelings might show up when you try to take this action?"

Examples of Internal Barriers:

- "I'll mess it up."
- "They won't care."
- "I don't deserve this."

- “It’s too hard.”

ACT Strategies:

- Acceptance: Make space for discomfort instead of avoiding it.
- Defusion: Acknowledge thoughts without giving them control.
- Mindfulness: Stay grounded in the present moment.

Facilitator Script:

“Remember, values-based action is not about being fearless. It’s about being willing.”

8. Closing Summary and Grounding (5 minutes)

Key Takeaways:

- Values help anchor you in who you truly are, not who abuse told you to be.
- Even small steps count—especially when they’re chosen with intention.
- You can move toward meaning, even in the presence of fear or pain.

Closing Grounding Activity:

“Breathe in. Picture your chosen value like a compass in your chest—steady, quiet, guiding you. Let it remind you of your direction this week.”

Group Reflection and Sharing (10 minutes)

Prompt Questions:

- “What was meaningful or surprising in this session?”
- “How did it feel to reconnect with your values?”

- "What is one value-based action you're committing to this week?"

Example Reflections:

- *"It felt emotional to realize how far I've strayed from what matters to me."*
- *"Choosing a small action helped me feel empowered."*
- *"Naming my values reminded me I'm more than my trauma."*

Homework Assignment

1. Journal Reflection:

   Reflect on the values you identified today. Where do they show up in your life? Where are they missing?

2. Committed Action:

   Complete one value-aligned action this week. It should be small, specific, and meaningful to you.

3. Mindful Observation:

   Notice what thoughts or emotions arise as you move toward your value. Practice acceptance or defusion if resistance shows up.

Session 5: Cognitive Defusion (ACT Focus)

Session Objectives

1. Help participants understand how thoughts impact emotional regulation.

2. Teach and practice cognitive defusion techniques to reduce the impact of distressing thoughts.
3. Foster a new relationship with self-critical thinking that promotes self-awareness and resilience.
4. Empower participants to act in alignment with values, even in the presence of negative thoughts.

Duration: 90 minutes

Facilitator Preparation

- Prepare materials or visual aids for defusion metaphors (e.g., leaves on a stream, passengers on a bus).
- Have sample negative thoughts written down to use in exercises.
- Set up space for experiential and reflective work.

Session Structure

1. Icebreaker: Check-In (5 minutes)

Prompt Questions:

"What's one word that describes how you're feeling today?"

"What was your experience taking a committed action based on your values last week?"

"Did any thoughts try to talk you out of doing it?"

Example Responses:

- *"Empowered – I set a boundary and stuck with it, even though I felt afraid."*

- *"Exhausted – The thought 'I'm not worth it' kept showing up."*
- *"Hopeful – I did something creative again, and it made me feel like myself."*

2. Review of Previous Session and Homework (5 minutes)

Discussion Prompt:

"What value-based action did you choose last week? What showed up—emotionally or mentally—as you took that step?"

Common Barriers Shared:

- Fear of failure
- Thoughts of unworthiness
- Avoidance due to self-doubt
- Discomfort with visibility or vulnerability

Normalize:

"Those responses are normal. Today we'll explore how to relate to those difficult thoughts differently."

3. Introduction to Cognitive Defusion (10 minutes)

Key Concepts:

- **Fusion** is when we're entangled with our thoughts and treat them as absolute truth.

E.g., *"I'm unlovable" feels like a fact, not just a thought.*

- **Defusion** helps us step back and observe our thoughts without letting them dictate our behavior.

Facilitator Script:

"You are not your thoughts. Just because your mind says something doesn't make it true or important."

4. Common Thought Patterns from Emotional Abuse (5 minutes)

Examples of Common Thoughts:

- *"I'm not good enough."*
- *"I'll always mess things up."*
- *"No one could truly care about me."*
- *"I can't do this—I'm too broken."*

Prompt:

"Which of these thoughts have shown up for you? What's one that tends to hook you the most?"

5. Teaching Through Defusion Metaphors (20 minutes)

Present a few of the following metaphors. Invite discussion after each.

1. Leaves on a Stream

"Imagine sitting by a stream. Each thought is a leaf. Watch them float by without grabbing onto any of them."

✅ Practice together for 2–3 minutes. Use a guided script.

2. Passengers on a Bus

"Your thoughts are passengers yelling directions. But you're the driver. You choose where the bus goes."

✅ Prompt: "What would it look like to keep driving toward your values even with those passengers shouting?"

3. Radio Static

"Negative thoughts are like background noise. You can hear them, but you don't have to tune in."

✅ Prompt: "What thoughts have been on 'repeat' for you like a stuck radio station?"

4. Thanking the Mind

"When a painful thought shows up, say: 'Thanks, mind. I hear you.' Then move on."

✅ Practice: Choose one recurring thought and say aloud or silently, *"Thanks, mind."*

Reflection Questions:

- "Which metaphor helped you the most?"
- "Did anything shift when you related to your thoughts in this way?"

6. Defusion Exercises (25 minutes)

Facilitators guide participants through these short, experiential practices.

Exercise 1: "I'm Having the Thought That..."

- Take a distressing thought (e.g., "I'm a failure") and add:

- “I’m having the thought that I’m a failure.”
- “I notice I’m having the thought that I’m a failure.”

✅ **Discussion Prompt:** “What changed when you added that distance?”

Exercise 2: Silly Voice Technique

- Say a painful thought aloud in a cartoon voice or silly accent.

✅ **Reflection:** “How did this shift the emotional weight of the thought?”

Exercise 3: Labeling Thoughts

- Notice and label thoughts in real-time:
  - “That’s a judging thought.”
  - “That’s a comparing thought.”
  - “That’s a fear thought.”

✅ Practice for 1–2 minutes silently.

Exercise 4: Word Repetition

- Repeat a distressing word (e.g., “worthless”) 30 times until it loses meaning.

✅ Prompt: “What did you notice after repeating the word over and over?”

Exercise 5: Mindful Object Observation

- Focus attention fully on a simple object (e.g., a stone or pencil).

- Use this as a metaphor: “We can observe our thoughts like we observe this object—curiously, without judgment.”

7. Defusion, Emotion Regulation & Values (10 minutes)

Facilitator Script:

“When we defuse from a thought like ‘I’m a failure,’ we can act according to our values instead of reacting in fear or shame.”

Example Scenario:

- Thought: “I’m too broken to reach out.”
- **Fused reaction**: Isolate and shut down.
- **Defused response**: Acknowledge the thought, then send a message to a friend anyway.

Prompt:

“What thoughts get in the way of your values? How could defusion help?”

8. Closing Summary and Grounding (5 minutes)

Key Takeaways:

- Defusion is not about controlling or eliminating thoughts.
- It’s about changing your relationship with them.
- You are the observer—not the voice in your head.

Closing Mindfulness Practice:

“Take a deep breath. Notice the space between your thoughts. Imagine those thoughts gently floating away—while your values stay grounded like roots beneath your feet.”

Group Reflection and Sharing (10 minutes)

Prompt Questions:

- “Which defusion technique was most helpful for you?”
- “How did your experience shift when you stepped back from a painful thought?”
- “What thought might you try to defuse this week?”

Example Responses:

- *“Saying ‘Thanks, mind’ actually helped me feel less trapped.”*
- *“Repeating ‘I’m not good enough’ in a cartoon voice made me realize how silly it sounded.”*

Homework Assignment

1. **Daily Defusion Practice**

   Choose one of the following techniques and use it once per day:

   - “I’m having the thought that…”
   - Leaves on a Stream visualization
   - Thought labeling

2. **Reflection Journal**

   Record one thought you defused, how it made you feel, and what action you took next.

3. **Continue Practicing Value-Based Action**

   Don't wait until the thought goes away—practice acting from values, even when difficult thoughts are present.

Session 6: Behavioral Activation & Committed Action

(CBT/ACT Integration)

Session Objectives

1. Increase emotional regulation and psychological well-being through value-driven behavioral engagement.
2. Identify avoidance patterns related to emotional abuse.
3. Use **Behavioral Activation (CBT)** and **Committed Action (ACT)** to promote small, meaningful changes.
4. Help participants plan and implement real-world activities aligned with their values, despite emotional discomfort.

Duration: 90 minutes

Facilitator Preparation

- Prepare handouts or worksheets for identifying avoidance behaviors.
- Bring a list of value-driven action examples.
- Provide a SMART goals worksheet.
- Arrange room for quiet reflection and group discussion.

Session Structure

1. Icebreaker: Check-In (5 minutes)

Prompt:

"What one word describes how you're feeling today?"

"What came up for you when you practiced cognitive defusion last week?"

"Did defusion help you respond differently to any thoughts?"

Example Reflections:

- *"Relieved – I saw that my thought wasn't the truth, just noise."*
- *"Proud – I reached out to someone despite thinking I'd be rejected."*
- *"Wary – I tried defusion, but the thought came back stronger later."*

2. Review of Homework & Session 5 (10 minutes)

Discussion Questions:

- "Which defusion technique did you use?"
- "What did you notice about your thoughts and behavior after defusing?"

Common Reflections:

- *"I kept saying 'I'm having the thought that...' and it softened my inner critic."*
- *"The 'silly voice' trick made me laugh at something that used to crush me."*

Facilitator Summary:

“Now that we’ve practiced stepping back from thoughts, we’ll focus on what you want to move toward—what matters most to you.”

3. Introduction to Behavioral Activation (10 minutes)

Definition:

Behavioral Activation (BA) helps reduce emotional distress by encouraging engagement in **meaningful, pleasurable, or value-based activities**, even when motivation is low.

Link to ACT:

In ACT, this is known as **committed action**—doing what matters even when difficult thoughts or feelings arise.

Facilitator Script:

“Emotional abuse can lead to avoidance—of people, hobbies, or responsibilities. The goal today is to gently re-engage with life, guided by your values.”

4. Identifying Avoidance Behaviors (15 minutes)

Exercise:

Provide an **Avoidance Worksheet** and ask participants to reflect on:

- What have you been avoiding?
- What emotions or thoughts are connected to the avoidance?
- What has been the short-term relief and long-term cost?

Examples:

- *Avoiding social events → Fear of rejection → Short-term comfort, long-term loneliness*
- *Avoiding creative expression → Shame of not being good enough → Short-term safety, long-term disconnection from joy*

Prompt for Sharing:

"What's something you've been avoiding that used to matter to you?"

5. Connecting Values to Action (5 minutes)

Reminder: Revisit the values from Session 4.

Prompt:

"Think about one of your core values. What's one small thing you could do this week that would express this value?"

6. SMART Goal-Setting Activity (20 minutes)

Explain SMART Goals:

- **Specific** – What exactly will you do?
- **Measurable** – How will you know it's done?
- **Achievable** – Is it realistic and manageable?
- **Relevant** – Does it connect to a value?
- **Time-bound** – When will you do it?

Examples:

- *Value: Connection → Goal: Call my sister for 10 minutes on Friday afternoon.*

- *Value: Growth → Goal: Journal for 15 minutes after work on Monday and Wednesday.*

Participant Activity:

- Use a worksheet or group support to write 1–2 SMART goals.

Group Discussion:

"Who would like to share their value-based goal for the week?"

7. Behavioral Experiments (20 minutes)

Definition:

A behavioral experiment is a way to **test** your assumptions and predictions (e.g., "They'll reject me" or "I'll fail") through action.

Facilitator Script:

"We often avoid things because of fear-based predictions. Let's gently test those fears—by taking action and seeing what actually happens."

Instructions:

1. Identify a feared situation or avoided action.
2. Write down the feared outcome.
3. Plan a small action.
4. Afterward, observe the real outcome vs. the predicted one.

Examples:

- Prediction: *"If I express a need, they'll leave me."*

- Experiment: *Send a message stating a boundary.*
- Outcome: *They respected it.*

8. Overcoming Emotional Barriers (5 minutes)

Prompt:

"What emotions or thoughts might try to block you from completing your goal?"

Strategies:

- **Acceptance**: "Yes, I feel anxious, and I can still act."
- **Defusion**: "I notice the thought 'I'll mess up,' and I'll take the action anyway."
- **Mindfulness**: Breathe and focus on the present.

9. Closing & Grounding Exercise (5 minutes)

Recap Key Points:

- Avoidance protects in the short term but harms in the long term.
- Action aligned with values promotes healing, confidence, and connection.
- You don't need to feel ready—you just need to be willing.

Grounding Exercise:

"As we close, place your hand on your heart. Breathe in. Think of the value you'll act on this week. Let it guide you gently forward.

Group Reflection and Sharing (10 minutes)

Discussion Prompts:

- "What did it feel like to name and plan a values-based goal?"
- "How do you feel about trying a behavioral experiment this week?"
- "What fears or hopes do you have around taking that action?"

Example Responses:

- *"It feels scary, but I'm tired of avoiding what matters."*
- *"It's empowering to know I can try—even if it's messy."*

Homework Assignment

1. **Complete Your SMART Goal**

   Take action on the value-aligned behavior you identified.

2. **Behavioral Experiment Reflection**

   Write down:

   - What you predicted would happen.
   - What actually happened.
   - How you felt before and after.

3. **Continue Mindfulness or Defusion Practice**

   Use breathing or thought-observation techniques to stay grounded when discomfort arises.

Session 7: Self-Acceptance & Stress Reduction

(ACT & CBT Integration)

Session Objectives

1. Cultivate self-acceptance as a foundation for healing after emotional abuse.
2. Reduce shame, self-blame, and negative self-talk through ACT and CBT tools.
3. Teach cognitive restructuring and self-compassion techniques.
4. Introduce grounding and stress-reduction skills that support long-term emotion regulation.

Duration: 90 minutes

Facilitator Preparation

- Prepare handouts with positive affirmations, thought-challenging prompts, and self-compassion exercises.
- Print or display a cognitive restructuring worksheet.
- Create a calm, comfortable space for reflection and grounding work.

Session Structure

1. Icebreaker: Emotional Check-In (5 minutes)

Prompt:

"What's one word to describe how you feel today?"

"How did your behavioral activation or committed action go this week?"

"What did you notice—emotionally or mentally—before, during, and after your action?"

Example Responses:

- *"Proud – I finally did something I've been putting off for months."*
- *"Tense – My fear told me I'd fail, but I did it anyway."*
- *"Disappointed – I didn't follow through, but I learned what blocks me."*

2. Review of Session 6 and Homework (10 minutes)

Prompt for Discussion:

"What value-aligned goal did you choose? How did it feel to act on it, or to try and struggle with it?"

Reflection Focus:

- What internal obstacles showed up?
- How did you use ACT or CBT tools to move forward?

Normalize:

"Avoidance is deeply ingrained after emotional abuse. Every small step forward matters."

3. The Need for Self-Acceptance in Recovery (10 minutes)

Key Concepts:

- Emotional abuse often implants messages of **unworthiness, guilt, and shame**.
- Self-acceptance is not approval of everything, but acknowledging ourselves with compassion.

Facilitator Script:

“Many survivors carry the voice of the abuser in their own head. Today, we’ll begin replacing that voice with something more truthful—and kinder.”

4. Identifying Self-Critical Thoughts (10 minutes)

Activity:

Ask participants to write down 1–2 recurring **self-critical thoughts** that show up frequently.

Examples:

- *“I’m too broken to be loved.”*
- *“It was my fault—they treated me that way.”*
- *“I can’t do anything right.”*

Discussion Prompt:

“Where do you think these thoughts came from? Are they really yours?”

Normalize: These thoughts often mimic the language of past abuse or trauma.

5. CBT Skill: Thought Challenging (15 minutes)

Teach Cognitive Restructuring:

- Identify the thought.
- Examine the evidence **for and against** it.
- Generate a **more balanced, compassionate response**.

Worksheet Example:

- Thought: “I’m a failure.”

- Evidence For: “I messed up that one job.”
- Evidence Against: “I’ve succeeded at other things. I’m learning.”
- Balanced Thought: “I make mistakes, but that doesn’t make me a failure.”

Prompt:

“Choose one self-critical thought and walk through this process with us or in your journal.”

Optional Pair Exercise:

If safe, allow pairs to share and help each other reframe.

6. ACT Skill: Self-as-Context & Self-Compassion (15 minutes)

Key Concepts:

- You are **not** your thoughts, feelings, or past experiences.
- **Self-as-context**: The "observer" in you who notices all thoughts and feelings but is untouched by them.

Guided Visualization: “Noticing the Noticer” (5 minutes):

“Close your eyes. Notice that you are aware of your thoughts… Now notice that you are aware **of being aware**... That deeper self is always here, whole and unbroken.”

Debrief Prompt:

“What did it feel like to connect with the ‘you’ that observes, not judges?”

7. Self-Compassion Practice (10 minutes)

Prompt:

“Imagine someone you care about spoke to themselves the way you speak to yourself. What would you want to say to them instead?”

Exercise: Write a compassionate response to your self-critical thought.

Examples:

- *“You’re doing the best you can.”*
- *“You didn’t deserve what happened.”*
- *“You are healing—even when it’s messy.”*

Optional Prompt: Write a letter to yourself from your “wise and loving inner voice.”

8. Grounding & Stress Reduction Techniques (10 minutes)

Introduce simple, effective ways to manage acute stress and emotional flooding.

Techniques:

1. **5-4-3-2-1 Grounding**
    - Name 5 things you see, 4 you can touch, 3 you hear, 2 you smell, 1 you taste.
2. **Progressive Muscle Relaxation**
    - Tense and release muscle groups one by one.
3. **Box Breathing**
    - Inhale 4, hold 4, exhale 4, hold 4.

Group Practice:

Guide a 3-minute grounding session using one of the above.

Prompt:

"Which of these techniques felt calming or useful? When might you use it?"

9. Closing Reflection and Summary (5 minutes)

Key Messages:

- Your inner critic is not the truth—it's a leftover survival response.
- You can learn to talk to yourself with kindness and strength.
- Grounding and self-compassion reduce shame and help regulate difficult emotions.

Closing Script:

"You've survived so much. You're still here. That means you have more healing ahead—and more joy to discover."

Group Reflection (10 minutes)

Discussion Prompts:

- "What self-critical thought are you ready to challenge or soften?"
- "How did it feel to speak to yourself more compassionately?"
- "What tool from today would you like to use this week?"

Example Shares:

- *"It felt strange at first to be kind to myself—but good."*
- *"The grounding helped when I felt overwhelmed."*

Homework Assignment

1. **Thought Reframing Practice:**

   Choose one recurring self-critical thought.

   - Identify it
   - Challenge it
   - Write a balanced, kind alternative

2. **Self-Compassion Letter:**

   Write a short note to yourself using the tone and words you'd use for a dear friend.

3. **Grounding Technique Daily Use:**

   Practice one of the grounding tools during a moment of stress or rumination.

Session 8: Rebuilding Identity & Empowerment

(ACT & CBT Integration)

Session Objectives

1. Support participants in reclaiming a sense of identity and self-worth lost to emotional abuse.
2. Help participants define themselves by values, not past trauma or abuser narratives.
3. Foster empowerment through boundary-setting, voice-building, and narrative reframing.
4. Cultivate a sense of personal agency and hope.

Duration: 90 minutes

Facilitator Preparation

- Prepare handouts: Identity Rebuilding Worksheet, Empowering Beliefs List, Boundary-Setting Prompts.
- Provide creative supplies if doing visual or metaphor-based identity exercises.
- Create a welcoming, affirming space.

Session Structure

1. Emotional Check-In (5 minutes)

Prompt:

"What's one word that describes how you're showing up today?"

"How did your self-compassion or thought-challenging practice go last week?"

"What did you notice about how you treat yourself?"

Examples:

- *"More gentle – I caught myself spiraling and paused instead."*
- *"Doubtful – It's hard to believe the new thoughts sometimes."*
- *"Lighter – I felt proud of how I responded to myself."*

2. Review of Session 7 & Homework (10 minutes)

Discussion Questions:

- "What was it like to write a compassionate note to yourself?"
- "How did grounding affect your response to stress or negative thoughts?"

Normalize:

“Rewriting inner narratives takes time—but each act of self-kindness chips away at old shame.”

3. Emotional Abuse and Identity Erosion (10 minutes)

Facilitator Notes:

- Emotional abuse often strips survivors of autonomy, self-trust, and identity.
- Many survivors internalize abusive labels (e.g., "needy", "overreacting", "not good enough").

Discussion Prompt:

“What parts of yourself were silenced, suppressed, or distorted in that relationship?”

Examples:

- *“My creativity—I was told it was a waste of time.”*
- *“My assertiveness—I was made to feel aggressive.”*
- *“My confidence—I was constantly questioned and criticized.”*

4. Who Are You Without the Abuse? (15 minutes)

Activity: Identity Rebuilding Exercise

Prompt participants to journal or reflect on:

- What brings you joy?
- What do you value most in yourself and others?
- What did you love before the relationship?

- When did you feel most like yourself?

Optional Creative Prompts:

- "Draw or list five words or images that represent the *real you*."
- "Describe a version of yourself not defined by fear or trauma."

Discussion Prompt:

"What parts of yourself do you want to reclaim or nurture moving forward?"

5. Narrative Reframing: From Surviving to Empowering (10 minutes)

Teach:

You are not your trauma—you are the person who lived through it and is still becoming.

Activity: Rewriting the Narrative

Participants complete the sentence:

- *"I used to believe I was ____, because of ____. Now I know I am ____."*

Examples:

- *"I used to believe I was broken because of how I was treated. Now I know I'm healing and resilient."*
- *"I used to believe I was too much. Now I know I am expressive, and that's a strength."*

Group Sharing (Optional but powerful):

Invite a few to share their revised self-narratives.

6. Empowerment Through Boundaries (15 minutes)

Key Points:

- Boundaries are a declaration of self-worth.
- Empowerment includes learning to say no, protect your energy, and voice your needs.

Prompt:

"Where in your life do you need stronger boundaries to protect your healing?"

Examples:

- Time boundaries with draining people
- Emotional boundaries with manipulative family members
- Social media boundaries to avoid triggers

Boundary-Setting Scripts:

- "I'm not available for that right now."
- "I don't feel comfortable discussing this."
- "That crosses a line for me."

Practice:

Invite participants to write or roleplay one boundary they'd like to set.

7. Values-Based Empowerment (10 minutes)

Prompt:

"Who do you want to be—*despite* the trauma?"

"What kind of life do you want to create, and what values will guide you?"

Examples:

- *"I want to live with integrity and compassion."*
- *"I want to show up with courage, even when it's hard."*

Facilitator Script:

"Empowerment doesn't mean perfection. It means choosing yourself—again and again."

8. Grounding in Strength & Hope (5 minutes)

Closing Visualization:

"Picture yourself a year from now. You are stronger, more self-connected, and guided by your values. You speak your truth, honor your needs, and carry yourself with dignity. That version of you is already within you—growing stronger each day."

Group Reflection (10 minutes)

Prompt Questions:

- "What part of yourself are you most excited to reclaim?"
- "What does empowerment mean to you now?"
- "What do you want to tell your past self who thought healing wasn't possible?"

Example Shares:

- *"I'm reclaiming my voice."*
- *"Empowerment means making choices that serve me, not just others."*
- *"I want to tell my past self: You didn't deserve it, and you're going to rise."*

Homework Assignment

1. Identity Journal Reflection:

   Write about who you are becoming. Use values, traits, and dreams—not trauma—to define yourself.

2. Set One Boundary This Week:

   It can be small, like saying no or expressing a need. Reflect on how it felt before and after.

3. Affirmation Practice:

   Choose or create 1–2 empowering affirmations and say them daily. Example:

   - "I choose myself."
   - "I am allowed to take up space."
   - "I am whole and healing."

Session 9: Closure, Reflection & Future Planning

(Integration & Transition)

Session Objectives

1. Celebrate participant growth and resilience over the 9-week journey.
2. Reflect on emotional, cognitive, and behavioral progress.
3. Create a personalized plan for ongoing healing, self-care, and boundary maintenance.

4. Facilitate meaningful group closure and a sense of completion.

Duration: 90 minutes

Facilitator Preparation

- Bring memory prompts or visual timeline of session themes.
- Prepare a Closure & Reflection Workbook or handout.
- Optional: Provide parting gifts, printed affirmations, or self-care resources.

Session Structure

1. Opening Grounding & Check-In (5 minutes)

Prompt:

"Take a deep breath. Feel the ground beneath your feet. You've made it to Session 9."

"What one word captures how you feel about this moment?"

Examples:

- *"Proud" – "I didn't think I'd stick with this, but I did."*
- *"Nervous" – "I'm afraid to lose this space."*
- *"Grateful" – "This group helped me find myself again."*

2. Guided Reflection: Looking Back (15 minutes)

Use a handout or journal prompt to guide participants through:

Reflect on Progress:

- "What brought you to this program?"

- “What were you struggling with then?”
- “What tools or shifts have helped you most?”

Reflect on Growth:

- “How have your thoughts changed?”
- “How do you treat yourself differently now?”
- “What boundaries have you strengthened?”

Group Sharing (Optional):

Invite participants to share one way they’ve changed or one takeaway they’re proud of.

3. Timeline Review: Revisiting Each Session (10 minutes)

Facilitator briefly recaps highlights of each session:

1. Session 1 – Creating safety & naming emotional abuse
2. Session 2 – Psychoeducation & stress response
3. Session 3 – Mindfulness & acceptance of pain
4. Session 4 – Clarifying values & committed action
5. Session 5 – Defusion from negative thoughts
6. Session 6 – Behavioral activation
7. Session 7 – Self-compassion & stress regulation
8. Session 8 – Rebuilding identity & empowerment

Prompt:

“Which session impacted you the most—and why?”

4. Self-Care & Healing Plan (20 minutes)

Activity: Build a Personalized Self-Care Plan

Sections:

- Daily Practices (e.g., mindfulness, journaling, grounding)
- Support System (trusted people, therapist, group, crisis contacts)
- Boundaries to Maintain
- Warning Signs to Watch For (e.g., emotional exhaustion, inner critic)
- Coping Tools When Triggered

Prompt:

“How will you protect your healing moving forward?”

Facilitator Encouragement:

“This plan is not about perfection—it’s about staying in relationship with your healing.”

5. Preparing for the Transition (10 minutes)

Discuss Common Feelings at the End:

- Grief or sadness about losing a safe space
- Fear about handling things alone

- Pride in completing something meaningful

Normalize:

“Ending doesn’t mean you’re on your own. You’re leaving with tools, insight, and inner strength.”

Optional Suggestions:

- Continue therapy or join a support group
- Form a peer support accountability group
- Revisit the materials weekly for 9 weeks as a refresher

6. Letter to Your Future Self (10 minutes)

Activity:

Write a letter to yourself to read in 1–3 months. Include:

- What you’ve learned
- What you want to remember
- Encouragement for the tough days
- A reminder of your worth

Prompt:

“What does your future self need to hear from you today?”

Option: Seal the letter or email it to yourself with a scheduled delivery.

7. Group Closure Ritual (15 minutes)

Ideas (choose one or combine):

- Each participant says one word to describe the group or their journey.
- Group reads a collective affirmation (e.g., "We are worthy. We are healing. We are not alone.")
- Participants each light a candle, place a flower, or write a word on a shared board to symbolize their growth.

Facilitator Closure Script:

"You have all shown incredible strength, vulnerability, and courage. This space was powerful because of *you*. The healing journey is not linear—but you've already proven you can take the next step, and the one after that."

8. Final Affirmation & Goodbye (5 minutes)

Facilitator Reads (or invite the group to repeat):

"I am no longer defined by what was done to me.
I am not broken—I am becoming.
I trust my voice, I honor my needs, and I walk in my worth."

Optional Parting Gifts:

- Healing stones
- Affirmation cards
- Printed quotes
- Personal notes of appreciation

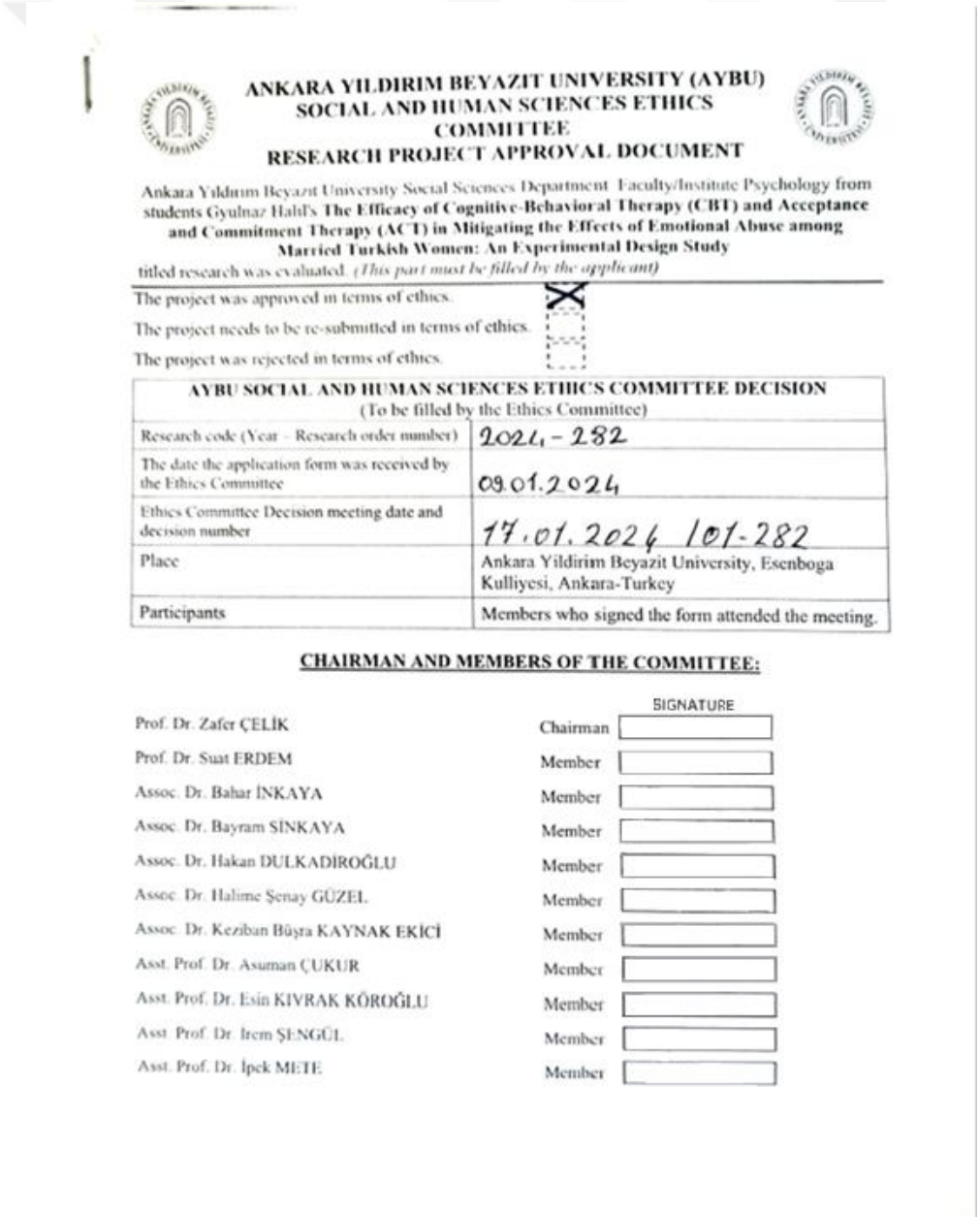
Homework / Ongoing Practice

1. Self-Care Plan – Commit to reviewing and updating it weekly.

2. Read Your Letter – Revisit your letter in 1–3 months.

3. Stay Connected – Use your support systems. Healing doesn't end—it evolves.

6.9. APPENDIX-9: ETHICAL APPROVAL FORM



ANKARA YILDIRIM BEYAZIT UNIVERSITY (AYBU)
SOCIAL AND HUMAN SCIENCES ETHICS COMMITTEE
RESEARCH PROJECT APPROVAL DOCUMENT

Ankara Yıldırım Beyazıt University Social Sciences Department Faculty/Institute Psychology from students Gyulnaz Halil's **The Efficacy of Cognitive-Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT) in Mitigating the Effects of Emotional Abuse among Married Turkish Women: An Experimental Design Study** titled research was evaluated. *(This part must be filled by the applicant)*

The project was approved in terms of ethics.	☒
The project needs to be re-submitted in terms of ethics.	☐
The project was rejected in terms of ethics.	☐

AYBU SOCIAL AND HUMAN SCIENCES ETHICS COMMITTEE DECISION (To be filled by the Ethics Committee)	
Research code (Year – Research order number)	2024 - 282
The date the application form was received by the Ethics Committee	09.01.2024
Ethics Committee Decision meeting date and decision number	17.01.2024 /01-282
Place	Ankara Yildirim Beyazit University, Esenboga Kulliyesi, Ankara-Turkey
Participants	Members who signed the form attended the meeting.

CHAIRMAN AND MEMBERS OF THE COMMITTEE:

		SIGNATURE
Prof. Dr. Zafer ÇELİK	Chairman	
Prof. Dr. Suat ERDEM	Member	
Assoc. Dr. Bahar İNKAYA	Member	
Assoc. Dr. Bayram SİNKAYA	Member	
Assoc. Dr. Hakan DULKADİROĞLU	Member	
Assoc. Dr. Halime Şenay GÜZEL	Member	
Assoc. Dr. Keziban Büşra KAYNAK EKİCİ	Member	
Asst. Prof. Dr. Asuman ÇUKUR	Member	
Asst. Prof. Dr. Esin KIVRAK KÖROĞLU	Member	
Asst. Prof. Dr. İrem ŞENGÜL	Member	
Asst. Prof. Dr. İpek METE	Member	

6.10. APPENDIX-10: CERTIFICATE FOR ACCEPTANCE AND COMMITMENT TRAINING



Certificate of Participation

THIS CERTIFICATE IS AWARDED TO

GYULNAZ HALİL

has been awarded this participation certificate by completing 36 hours of a theoretical training on Acceptance and Commitment Therapy (ACT) organized by Assoc. Prof. Dr. Çağdaş Öykü MERİÇ, on 24-25th of February, 23-24th of March, 20-21th of April 2024.

ASSOC. PROF. DR ÇAĞDAŞ ÖYKÜ MERİÇ
Cognitive and Behavioral Therapies
and Acceptance and Commitment
Therapy Trainer