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

ACCEPTANCE AND COMMITMENT THERAPY (ACT)-BASED GROUP INTERVENTIONS FOR DIVORCED SINGLE PARENTS: A RANDOMIZED CONTROL TRIAL

Ph.D. DISSERTATION

Sibel ARSLAN

DEPARTMENT OF PSYCHOLOGY

Ankara, 2024

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

ACCEPTANCE AND COMMITMENT THERAPY (ACT)-BASED GROUP INTERVENTIONS FOR DIVORCED SINGLE PARENTS: A RANDOMIZED CONTROL TRIAL

Ph.D. DISSERTATION

Sibel ARSLAN

DEPARTMENT OF PSYCHOLOGY

Advisor
Prof. Dr. Hüdayar CIHAN

Ankara, 2024

APPROVAL PAGE

The thesis study titled as “Acceptance and Commitment Therapy (ACT)-Based Group Interventions for Divorced Single Parents: A Randomized Control Trial” prepared by Sibel ARSLAN was unanimously approved by the following jury as a Ph.D. Thesis in Ankara Yıldırım Beyazıt University Graduate School of Social Sciences Department of Psychology.

<table>
<tr><th colspan="2">Jury Member</th><th>Institution</th><th>Signature</th></tr>
<tr><td colspan="2">Prof. Dr. Hüdayar CIHAN</td><td rowspan="2">Ankara Yıldırım Beyazıt University</td><td rowspan="2"></td></tr>
<tr><td>Accept ☒</td><td>Reject ☐</td></tr>
<tr><td colspan="2">Asist. Prof. Dr. Emine İNAN</td><td rowspan="2">Ankara Yıldırım Beyazıt University</td><td rowspan="2"></td></tr>
<tr><td>Accept ☒</td><td>Reject ☐</td></tr>
<tr><td colspan="2">Asist. Prof. Dr. Elif Emir ÖKSÜZ</td><td rowspan="2">Ankara Yıldırım Beyazıt University</td><td rowspan="2"></td></tr>
<tr><td>Accept ☒</td><td>Reject ☐</td></tr>
<tr><td colspan="2">Prof. Dr. Hatice DEMİRBAŞ</td><td rowspan="2">Ankara Hacı Bayram Veli University</td><td rowspan="2"></td></tr>
<tr><td>Accept ☒</td><td>Reject ☐</td></tr>
<tr><td colspan="2">Asist. Prof. Dr. Emel GENÇ</td><td rowspan="2">Bartın University</td><td rowspan="2"></td></tr>
<tr><td>Accept ☒</td><td>Reject ☐</td></tr>
</table>

Thesis Defense Date: 18.07.2024

I certify that the student has fulfilled the requirements for a Ph.D. Thesis in Ankara Yıldırım Beyazıt University Graduate School of Social Sciences Department of Psychology

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

DECLARATION

I hereby declare that all information in this thesis has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all materials and results that are not original to this work; otherwise, I accept all legal responsibility. (Date: 05/07/2024)

Sibel ARSLAN

ACKNOWLEDGMENTS

I would like to begin by expressing my deepest gratitude to myself for persevering on this journey of self-improvement with patience and determination, not just during the doctoral process but throughout my entire life. I am proud of my relentless effort and dedication toward achieving this goal.

Secondly, I extend my heartfelt thanks to my daughter, who patiently waited for me during my study time, and to my mother, husband, and siblings, whose unwavering love and support sustained me throughout this process. I am truly fortunate to have them in my life.

I am deeply grateful to my advisor, Prof. Dr. Hüdayar CIHAN, for her invaluable guidance and support throughout my doctoral program. I would also like to express my sincere appreciation to Asst. Prof. Emel GENÇ and Asst. Prof. Emine İNAN for serving on my thesis committee and offering valuable feedback and suggestions. Additionally, I am thankful to Prof. Dr. Hatice DEMİRBAŞ and Asst. Prof. Elif EMİR ÖKSÜZ for being part of my thesis defense committee and sharing their insights.

My gratitude extends to my friends, Esra ORAS and Elif Beyza KOŞ YALVAÇ, for their contributions to the intervention program developed for my thesis and for their essential feedback. I also wish to thank Tuba KILIÇ, Esra ORAS, and other friends who shared my research with their networks and encouraged participation in the intervention program.

I would like to express my sincere thanks to all the participants in the research for their time and willingness to share their experiences. This work would not have been possible without their contributions.

Lastly, I would like to express my respect and gratitude to The Scientific and Technological Research Council of Türkiye (TÜBİTAK) for the support during my Ph.D. journey.

ÖZET

Boşanmış Tek Ebeveynlere Yönelik Kabul ve Kararlılık Terapisi Temelli Grup Müdahalesi: Randomize Kontrollü Çalışma

Boşanma sonrasında özellikle ebeveynler için zorlayıcı olan ayrılığın ilk dönemlerinde psikolojik sorunlar yaşanmaktadır. Bu zor dönem sadece bireysel psikolojik sorunları etkilemekle kalmamakta aynı zamanda ebeveynlik süreçlerini ve çocuk-ebeveyn ilişkisini de etkilemektedir. Bu nedenle, tek ebeveynlerin psikolojik iyi oluşları, psikolojik esneklikleri ve ebeveynlik becerileri için desteklenmesine ihtiyaç vardır. Bu konuda dünya genelinde farklı müdahale programları geliştirilmiş olmakla birlikte Türkiye'de psikolojik esneklik, duygu düzenleme ve boşanma sonrası ebeveynlik konularını kapsayan bir psikolojik destek programının olmadığı tespit edilmiştir. Bu çalışmada boşanmış ebeveynlere yönelik Kabul ve Kararlılık Terapisi temelli grup müdahale programının psikolojik esneklik, duygu düzenleme becerileri, depresyon, kaygı, stres ve olumlu ebeveynlik davranışları üzerindeki etkisinin belirlenmesi amaçlanmıştır. Bu araştırma, ön test, son test, izleme ölçümlerini içeren randomize kontrollü deneysel bir çalışmadır. Nicel verileri derlemek amacıyla Psikolojik Esneklik Ölçeği, Duygu Düzenleme Ölçeği, Depresyon Kaygı Stres Ölçeği ve Alabama Ebeveynlik Ölçeği uygulanmıştır. Araştırmaya 6-18 yaş arası en az bir çocuğu olan 56 boşanmış ebeveyn dahil edilmiştir. Veriler ön test, son test ve izleme testi olmak üzere üç aşamada elde edilmiştir. Deney grubundaki 29 kişiye sekiz haftalık ortalama 90 dakika süren online seanslar uygulanmıştır. Bulgular boşanmış bireylere uygulanan programın bireylerin psikolojik esnekliklerini artırdığı, depresyon ve anksiyete düzeyini azalttığı ve bu etkilerin izleme sürecinde de devam ettiğini göstermiştir. Ancak, müdahale programı duygu düzenleme ve ebeveynlik uygulamaları açısından istatistiksel olarak anlamlı bir etki oluşturmamıştır. Sonuç olarak ACT temelli grup müdahalelerinin boşanmış ebeveynlerin hem psikolojik esnekliğini artırarak zorlayıcı durumlar karşısında onları desteklemek hem de depresyon ve anksiyete düzeyleri azaltarak psikolojik iyi oluşlarına katkı sunmak için faydalı olacağı sonucuna varmak mümkündür.

Anahtar Kelimeler: Kabul ve kararlılık terapisi, tek ebeveynlik, boşanma, esneklik, duygu düzenleme, depresyon, kaygı, stres.

ABSTRACT

Acceptance and Commitment Therapy (ACT)-Based Group Interventions for Divorced Single Parents: A Randomized Control Trail

Psychological challenges often arise after divorce, particularly during the initial stages of separation, which can be especially difficult for parents. This challenging period not only exacerbates individual psychological issues but also impacts parenting processes and the parent-child relationship. Therefore, it is crucial to support single parents in maintaining psychological well-being, enhancing psychological flexibility, and improving parenting practices. While various intervention programs have been developed globally to address these needs, it has been identified that Türkiye lacks a psychological support program for divorced individuals that integrates psychological flexibility, emotion regulation, and post-divorce parenting. This study aims to evaluate the effectiveness of an Acceptance and Commitment Therapy (ACT) based group intervention program for divorced parents on improving psychological flexibility, emotion regulation skills, depression, anxiety, stress levels, and positive parenting behaviors. The research adopts a pretest, posttest, follow-up, randomized controlled experimental design. To gather quantitative data, the Psychological Flexibility Questionnaire, Emotion Regulation Questionnaire, Depression Anxiety Stress Scale, and Alabama Parenting Questionnaire were administered. A total of 56 divorced parents, each with at least one child aged between 6 and 18 years, participated in the study. Data were collected at three stages: pretest, posttest, and follow-up. The intervention involved online sessions averaging 90 minutes each, conducted over eight weeks with 29 participants. The findings revealed that the intervention program significantly increased psychological flexibility and decreased depression and anxiety levels among the participants, with these effects persisting during the follow-up period. However, the program did not produce statistically significant effects on emotion regulation and parenting practices. In conclusion, ACT-based group interventions can be beneficial for divorced parents, offering support in navigating challenging situations by enhancing psychological flexibility and contributing to overall psychological well-being by reducing depression and anxiety levels.

Keywords: Acceptance and commitment therapy, single parenting, divorce, flexibility, emotion regulation, depression, anxiety, stress.

TABLE of CONTENTS

APPROVAL PAGE……i

DECLARATION……ii

ACKNOWLEDGEMENTS……iii

ÖZET……iv

ABSTRACT……...v

TABLE of CONTENTS……vi

LIST of SYMBOLS and ABBREVIATIONS……ix

LIST of FIGURES……x

LIST of TABLES……..xi

INTRODUCTION……..1

1. LITERATURE ……..5

1.1. Intervention Programs to Support Divorced People ……..5

1.2. Acceptance and Commıtment Therapy ……6

1.2.1. Philosophical and Theoretical Underpinning of ACT……..9

1.2.2. Functional Contextualism ……9

1.2.3. Relational Frame Theory……10

1.2.4. Basic Concepts of Acceptance and Commitment Therapy……13

1.2.5. ACT Model of Psychological Flexibility……18

1.2.6. Empirical Support for ACT……24

1.3. Emotion Regulation ……29

1.3.1. Emotion……...29

1.3.2. Emotion Regulation……30

1.4. Depression ……...32

1.5. Anxiety……36

1.6. Stress……37

1.7. Parenting……...39

1.7.1. Childcare……41

1.7.2. Positive Parenting……42
1.7.3. Parenting after Divorce……...44
2. METHOD……...47
2.1. Participants……....47
2.2. Measures……50
2.2.1. Demographic Form……50
2.2.2. Psychological Flexibility……...51
2.2.3. Emotion Regulation Questionnaire……51
2.2.4. Depression, Anxiety, Stress Scale……...51
2.2.5. Alabama Parenting Questionnaire……...52
2.2.6. Group Intervention Evaluation Form……..52
2.2.7. The Qualitative Interview Form……..53
2.3. Research Design……...53
2.4. Pilot Application. ……54
2.5. Procedure……56
2.6. Act-Based Group Program……...57
2.7. Data Analysis……61
3. RESULTS……..……..74
3.1. Findings from Descriptive Analysis……74
3.1.1. Demographic Findings……74
3.1.2. Descriptive Statistics of Scales……...78
3.1.3. Reliability Analysis of the Scales……...81
3.2. Findings from Testing the Hypothesis……82
3.2.1. Findings Related to the Hypothesis about Psychological Flexibility……82
3.2.2. Findings Related to the Hypothesis about Emotion Regulation ……97
3.2.3. Findings Related to the Hypothesis about Depression Anxiety and Stress ….102
3.2.4. Findings Related to the Hypothesis about Parenting ……...105

4. DISCUSSION……..……..……..110
4.1. Evaluation of Findings Obtained from Descriptive Statistics……110
4.2. Evaluation of Findings Obtained from Testing the Hypotheses……113
4.2.1. Evaluations Regarding the Hypothesis about Psychological Flexibility……..113
4.2.2. Evaluations Regarding the Hypothesis about Emotion Regulation……..119
4.2.3. Evaluations Regarding the Hypothesis about Depression Anxiety and Stress…….121
4.2.4. Evaluations Regarding the Hypothesis about Parenting……...125
4.3. Strengths……..……..……...130
4.4. Limitations……..……..……132
5. CONCLUSION and SUGGESTION…….134
6. REFERENCES……..……..…….137
7. APPENDICES……..……..……..161
Appendix 1: Demographic Form……...161
Appendix 2: Psychological Flexibility Scale……164
Appendix 3: Emotion Regulation Questionnaire……..166
Appendix 4: Depression Anxiety Stress Scale……..167
Appendix 5: Alabama Parenting Questionnaire……168
Appendix 6: Group Intervention Evaluation Form……...169
Appendix 7: Qualitative Interview Form……..170
Appendix 8: Informed Consent Form……171
Appendix 9: Ethical Committee Approval……173
Appendix 10: Psychological Flexibility Questionnaire Usage Permission……...174
Appendix 11: Emotion Regulation Questionnaire Usage Permission……...175
Appendix 12: Depression, Anxiety and Stress Scale Usage Permission……...176
Appendix 13: Alabama Parenting Questionnaire Usage Permission……177
Appendix 14: Program Invitation Announcement……....178

LIST of SYMBOLS and ABBREVIATIONS

ACT	: Acceptance and Commitment Therapy
APQ	: Alabama Parenting Questionnaire
ERQ	: Emotion Regulation Questionnaire
DASS	: Depression Anxiety Stress Scale
PFQ	: Psychological Flexibility Questionnaire

LIST of FIGURES

Figure 1. The hexaflex model of ACT……15
Figure 2. Participation information……49
Figure 3. Boxplot for PFQ measurements of experimental group……67
Figure 4. Boxplot for PFQ measurements of control group……67
Figure 5. Boxplot for ERQ measurements of experimental group……..68
Figure 6. Boxplot for ERQ measurements of control group……68
Figure 7. Boxplot for DASS measurements of experimental group……...69
Figure 8. Boxplot for DASS measurements of control group……69
Figure 9. Boxplot for APQ measurements of experimental group……..70
Figure 10. Boxplot for APQ measurements of control group……70
Figure 11. Summary of the analysis of the study……73

LIST of TABLES

Table 1. View of the research model……..……..…...53
Table 2. Content of the 8-week program……59
Table 3. Flow of the 8-week program……60
Table 4. Shapiro-Wilk normality test for the scores……62
Table 5. Skewness and kurtosis values of the scales of the experimental group…….65
Table 6. Skewness and kurtosis values of the scales of the control group……..66
Table 7. Distribution of the sample in terms of education and occupational status……75
Table 8. Distribution of the sample in terms of variables related to divorce……..76
Table 9. Distribution of the sample in terms of the post-divorce process……..77
Table 10. Values of PFQ subscales for the groups…….79
Table 11. Values of ERQ subscales for the groups……79
Table 12. Values of DASS subscales for the groups……..80
Table 13. Values of APQ subscales for the groups……81
Table 14. Descriptive statistics for PFQ total scores……...84
Table 15. Independent samples t-test for PFQ…….85
Table 16. Descriptive statistics for acceptance scores…….85
Table 17. Independent samples t-test for acceptance……..86
Table 18. Descriptive statistics for defusion scores……86
Table 19. Independent samples t-test for defusion……..87
Table 20. Independent samples t-test for mindfulness……88
Table 21. Descriptive statistics for self-as-context scores……...88
Table 22. Independent samples t-test for self-as-context……89
Table 23. Mann-Whitney U test results for PFQ scores of the groups……90
Table 24. Mauchly's sphericity test results for PFQ total, acceptance and defusion subscale of experimental group……91
Table 25. Descriptive statistics for PFQ total score of experimental group……92
Table 26. Repeated measures ANOVA results for the PFQ total score, acceptance and defusion scores of the experimental group……..92
Table 27. Repeated measures ANOVA bonferroni results of the PFQ total score of experimental group……..93
Table 28. Repeated measures ANOVA bonferroni results for acceptance scores of the experimental group……94

Table 29. Repeated measures ANOVA bonferroni results for the defusion subscale of the experimental group……..…95
Table 30. Friedman test results for the comparison of the PFQ total, self-as-context, mindfulness, values and acceptance subscales of experimental group……...95
Table 31. Wilcoxon signed-rank test results for experimental group PFQ and self-as-context subscale……..96
Table 32. Descriptive statistics for reappraisal score of the groups……98
Table 33. Independent samples t-test for reappraisal……..99
Table 34. Descriptive statistics for suppression score of the groups……...99
Table 35. Independent samples t-test for suppression score……..100
Table 36. Mann-Whitney U test results for suppression subscale posttest scores of the groups……..100
Table 37. Descriptive statistics for reappraisal subscale of experimental group……...101
Table 38. Mauchly's sphericity test results for the experimental group reappraisal…….101
Table 39. Repeated measures ANOVA results for the reappraisal scores of the experimental group……...101
Table 40. Friedman test results for suppression scores of the experimental group……..102
Table 41. Mann-Whitney U test results for DASS scores……104
Table 42. Friedman test results for DASS scores of the experimental group……104
Table 43. Wilcoxon signed-rank test results for anxiety of experimental group……...105
Table 44. Mann-Whitney U test results for positive parenting subscale scores……106
Table 45. Descriptive statistics for childcare scores……..107
Table 46. Independent samples t-test on childcare scores……107
Table 47. Friedman test results for positive parenting scores of the experimental group……...108
Table 48. Descriptive statistics for childcare subscale of experimental group……..108
Table 49. Mauchly's sphericity test results for childcare subscale……..109
Table 50. Repeated measures ANOVA results for childcare subscale of the experimental group……..109

INTRODUCTION

In recent years, the number of single-parent families due to divorce has been increasing both in the world and Türkiye. The European Statistical Office reported the rate of single-parent families in Europe as 14% (7.8 million) in 2020. In the USA, one out of every three children live with a single parent (Daryanani et al., 2016). According to the data of the Turkish Statistical Institute, while 7.6% of the total households consisted of single parents and children in 2014, this rate increased to 10.6 % in 2023 (TUIK, 2020). Looking at the divorce statistics, it was determined that while the number of divorced couples was 136 thousand 570 in 2020, it was 171 thousand 881 in 2023. When divorces are analyzed according to the duration of marriage, 33.4% of divorces occurred in the first five years of marriage, 21.7% in the 6-10 years of marriage, and 15.8% in the first 11-15 years of marriage. As a result of the finalized divorce cases, 171 thousand 881 couples were divorced in 2023, while 171 thousand 213 children were given custody. In addition, because of divorce cases, it is seen that the custody of the children was mostly given to the mother (74.9%) (TUIK, 2023).

Studies show that compared to other families single-parent families are generally at a disadvantage both systemically and individually. The psychological well-being of parents is negatively affected by the divorce process. However, divorce is a challenging life experience that has disturbing psycho-social effects not only for spouses but also for children. After the divorce, people need to regulate challenging emotions and develop healthy coping while adapting to the new life. Group interventions with divorced people provide a socially supporting environment. Parent groups, come together people with similar experiences and contribute to strengthening social support mechanisms. This support plays an important role in adapting to the new life and contributing to psychological well-being (Glazer et al., 2010). With the group processes individuals easily overcome emotional difficulties also by increasing problem-solving skills (Rais, 2007).

Considering the issues that ACT addresses based on psychological flexibility, it is suggested that it is advantageous for parents in terms of meeting the need to accept the life and associated emotions of the individual who is faced with unchangeable challenging

experiences (Biglan et al., 2008; Losada et al., 2015). Its usefulness for parents relates not only to individual well-being but also to the child's psychological response to the problems posed by challenging experiences and the associated emotional state. There are studies supporting significant changes in positive parenting behaviors along with a decrease in depression levels of parents receiving ACT-based intervention (Casselman & Pemberton, 2015; Moyer et al., 2018). In this respect, it is suggested that ACT is an intervention that helps parents cope with the stress and difficulties associated with children suffering from psychological distress (Byrne et al., 2021). Appropriate evaluation of children's behavior who have emotional difficulties after divorce and accepting feelings contributes to the strengthening of the parent-child relationship. This allows children to reduce externalizing behavior problems and parent-child conflicts (Ghochani et al., 2020). In this respect, it is thought that ACT may be a suitable supportive intervention for divorced parents.

A substantial number of programs are implemented around the world to support divorced parents and examine different types of therapy interventions. However, in the intervention programs developed in Türkiye, it is determined that studies generally focus only on parenting skills. No study has been found that focuses on the psychological well-being of parents or includes emotion regulation skills or psychological flexibility. This study is important in that it aims to both directly support the parents psychologically and indirectly improve positive parenting attitudes in the post-divorce period. In addition, this study has a critical importance in the literature as it aims to provide support to people regardless of gender after divorce, which is a phenomenon that is not easily socially accepted and psychologically supported.

The purpose of the research is to develop an ACT-based group program to support parents after divorce. This study aims to support single-parent families by developing emotion regulation skills, psychological flexibility, and positive parenting behavior while reducing depression, anxiety, and stress. It will be evaluated whether ACT-based interventions will be an effective tool in terms of various variables related to psychological well-being and supporting single parents after divorce. For this purpose, the hypotheses tested in the study are as follows:

H1: The ACT-based intervention will result in a significant difference between the experimental and control groups on psychological flexibility.

H1.1. The ACT-based intervention will result in a significant difference between the experimental and control groups on the Psychological Flexibility total score.

H1.2. The ACT-based intervention will result in a significant difference between the experimental and control groups on Acceptance.

H1.3. The ACT-based intervention will result in a significant difference between the experimental and control groups on Defusion.

H1.4. The ACT-based intervention will result in a significant difference between the experimental and control groups on Mindfulness.

H1.5. The ACT-based intervention will result in a significant difference between the experimental and control groups on Self-as-context.

H1.6. The ACT-based intervention will result in a significant difference between the experimental and control groups on Values.

H1.7. The ACT-based intervention will result in a significant difference within the experimental group on Psychological Flexibility total score between the pretest, posttest, and follow-up tests.

H1.8. The ACT-based intervention will result in a significant difference within the experimental group in Acceptance scores between the pretest, posttest, and follow-up tests.

H1.9. The ACT-based intervention will result in a significant difference within the experimental group on Defusion score between the pretest, posttest, and follow-up test.

H1.10. The ACT-based intervention will result in a significant difference within the experimental group on Mindfulness scores between the pretest, posttest, and follow-up tests.

H1.11. The ACT-based intervention will result in a significant difference within the experimental group on Self-as-context scores between the pretest, posttest, and follow-up tests.

H1.12. The ACT-based intervention will result in a significant difference within the experimental group on Values score between the pretest, posttest, and follow-up test.

H2: The ACT-based intervention will result in a significant difference between the experimental and control groups on emotion regulation skills.

H2.1. The ACT-based intervention will result in a significant difference between the experimental and control groups on the Reappraisal score.

H2.2. The ACT-based intervention will result in a significant difference between the experimental and control groups on the Suppression score.

H2.3. The ACT-based intervention will result in a significant difference within the experimental group on Reappraisal scores between the pretest, posttest, and follow-up tests.

H2.4. The ACT-based intervention will result in a significant difference within the experimental group on Suppression scores between the pretest, posttest, and follow-up tests.

H3: The ACT-based intervention will result in a significant difference between the experimental and control groups on Depression, Anxiety, and Stress levels.

H3.1. The ACT-based intervention will result in a significant difference between the experimental and control groups on Depression scores.

H3.2. The ACT-based intervention will result in a significant difference between the experimental and control groups on Anxiety scores.

H3.3. The ACT-based intervention will result in a significant difference between the experimental and control groups on Stress scores.

H3.4. The ACT-based intervention will result in a significant difference within the experimental group on Depression scores between the pretest, posttest, and follow-up tests.

H3.5. The ACT-based intervention will result in a significant difference within the experimental group on Anxiety scores between the pretest, posttest, and follow-up test.

H3.6. The ACT-based intervention will result in a significant difference within the experimental group on Stress scores between the pretest, posttest, and follow-up test.

H4: The ACT-based intervention will result in a significant difference between the experimental and control groups on Positive Parenting skills.

H4.1. The ACT-based intervention will result in a significant difference between the experimental and control groups on Positive Parenting scores.

H4.2. The ACT-based intervention will result in a significant difference between the experimental and control groups on Childcare scores.

H4.3. The ACT-based intervention will result in a significant difference within the experimental group on Positive Parenting scores between the pretest, posttest, and follow-up tests.

H4.4. The ACT-based intervention will result in a significant difference within the experimental group on Childcare scores between the pretest, posttest, and follow-up test.

1. LITERATURE

In this session, intervention programs developed for the divorced people, the Acceptance and Commitment Therapy approach, the concept of emotion regulation and depression, anxiety and stress, and parenting are elaborated. The research on the topics is included in this section within the scope of the theoretical framework of the research.

1.1. Intervention Programs to Support Divorced People

An intervention program called Parenting Through Change has been developed to support the parenting processes of mothers after divorce and to have a positive impact on children. Divorced mothers with children of primary school age participated in the study. The program consists of 14 sessions covering parenting practices (for example, non-coercive discipline, conditional encouragement, monitoring, and problem-solving) and other topics related to divorce (for example, regulation of negative emotions and management of interpersonal conflicts). In each session, the following topics were discussed in turn; encouraging children's cooperation effectively, encouraging with effective teaching techniques and conditional positive reinforcement, setting boundaries, promoting school success, developing skills, communicating with children, observing emotions, managing emotions, problem-solving, managing conflict, children's activities monitoring, work and play balance (Forgatch & DeGarmo, 1999). Similarly, another study developed the Fatherhood Through Change program for divorced and remarried fathers (DeGarmo & Jones, 2019). While the program applied to fathers with children between the ages of 4 and 12 had a direct effect on child adjustment problems and fathers' compulsive parenting, it had an indirect effect on child adjustment. Another program developed for single parents after divorce aimed to strengthen the mother-child relationship and teach effective positive discipline. The New Beginnings Program, which consists of 10-week group sessions, provides tools for parents to build stronger relationships with their children, encourages children to share their problems and concerns with their parents, and includes parents setting clearer rules and reducing misbehavior. After the program, children had better relationships with their parents, decreased aggression, decreased emotional problems, higher self-esteem, better grades, and less substance abuse. The program had a positive effect on mental health problems and internalization and externalization problems in children. Even six years after the program, it showed a 37% decrease in children's psychological disorder diagnoses, as

well as positive effects on psychological disorder symptoms, internalizing problems, externalizing problems, substance use, competence, and the number of sexual partners (Wolchik et al., 2007).

When we look at the intervention programs developed in this regard in Türkiye, the Divorce Adjustment Program for Single-Parent Families draws attention. The program is prepared for families who have a child/children between the ages of 9-15 and are divorced within three years. The program, consisting of six sessions, is conducted with the parents and children, and it is aimed to increase adaptation of the divorce. The program consists of sessions on understanding the divorce process, effective communication, problem-solving, effective coping with anger and stress, developing positive discipline, and discovering support. However, it is reported that the program is still under development and there are only three families in the experimental and control groups. In another study, the Divorce Adjustment Program for Mothers with Custody is developed. The 10-week program is developed for middle school students aged 12-14 whose parents are divorced, and their mothers have custody. The effectiveness of the program on children and mothers about divorce adjustment, psychological resilience, and family life satisfaction is supported (Halisdemir, 2020).

1.2. Acceptance and Commitment Therapy

The three primary components of ACT are acceptance, choice, and action. These components are encoded in the first letters of the word. The letter “A” stands for acceptance, the letter “C” stands for choice, and the letter “T” stands for take action. When these letters are brought together, they form the word "ACT" which emphasizes acting (Heffner & Eifert, 2004).

Behavioral therapies are divided into three generations: traditional behavioral therapy, cognitive-behavioral therapy, and third-wave behavioral therapy. ACT is one of the last waves of behavioral therapies. In recent years, third-wave behavioral therapies have begun to emerge, emphasizing the need to consider experiences in a broader context. Third wave behavioral therapies do not adopt the mechanistic approach unlike the first and the second wave therapies. The focus of third-wave therapies, unlike previous methods, is to identify the function of behavior and change the function rather than change the form and

content of the behavior. Therefore, the main goal is not to try to get rid of dysfunctional thoughts, but to accept thoughts and emotions as they are and to develop the ability to exhibit behaviors compatible with the goals in life (Pearson et al., 2010). These therapies draw attention to contextual and experiential change strategies such as acceptance, dissociation, conscious awareness, and values to change the function of the problematic psychological behavior if it cannot be changed (Kingston, 2008). Contrary to the previous therapy techniques, they focus on the relationship with the feelings and thoughts rather than directly intervening in the change of thoughts and feelings (Hayes & Fletcher, 2005). It is thought that change will occur not by changing the content of thoughts as in traditional cognitive behavioral therapies, but by changing the relationship with thoughts. When thoughts are treated as just thoughts and the relationship with them is reorganized, flexibility to act in line with the values increases (O'Brien et al., 2008).

The main aims of ACT, one of the third-wave behavioral therapies, are to eliminate the pressure of emotions and thoughts on behavior and to increase psychological and behavioral flexibility. Another purpose of ACT is to help people to live meaningfully rather than to feel good in life. ACT helps people accept themselves and others, identify “valuable” aspects of life, and act on these values with consistency and determination (Hayes et al., 1999).

When a problem occurs, instead of immediately labeling the behavior as "pathological", the goal of third-wave therapies is to strengthen the individual and enrich the behavioral repertoire (Hayes, 2004). In ACT, unwanted feelings and thoughts and even bodily symptoms are not considered abnormal. Instead of including people in a specific diagnostic category based on their symptoms, it focuses on how functional they are in different areas of life (Hayes et al., 1996). Unlike many other therapy models, ACT is a therapeutic approach focused on increasing psychological resilience, living in line with core values by accepting the inevitable pain rather than symptom reduction. In fact, instead of struggling with feelings and thoughts, a new relationship with these experiences is built (Eifert & Forsyth, 2005).

ACT also aims to help the person create a new behavioral repertoire. It is only possible by defining the client's core values and shaping behavioral patterns consistent with these values. In this respect, ACT is seen as an experiential therapy approach, rather than a

didactic approach (Kingston, 2008). In ACT, the actions that prevent a person from living according to personal values are seen as obstacles and this situation is considered as problems that require a clinical intervention. Most of these barriers are behaviors that lead people to avoid uncomfortable subjective experiences (Bolderston, 2013). For this reason, the reduction and termination of nonfunctional behaviors at the point of living life are in line with the values. It is argued that when clients accept past experiences, feelings, thoughts, and memories as part of their lives, instead of seeing them as obstacles, their lives will gain more meaning in line with values (Eifert & Forsyth, 2005).

In addition, ACT aims to be open to experiences and to live with a holistic awareness and consciousness. While ACT intends for a meaningful and valuable life, it also emphasizes the need to accept the inevitable pain that life brings. ACT emphasizes the function of behavior and the use of conscious awareness and acceptance as tools for change (Hayes, 2004). The conscious awareness exercises applied aim to increase the awareness of the context and develop the ability to pay attention to the signs in the context. Thus, individuals learn to expand their behavioral repertoire (Pearson et al., 2010).

One of the ways that ACT differs from traditional approaches is an approach to psychological pain. ACT considers psychological pain as one of the important elements of existence that every person has and as a normal state (Hayes et al., 1999). Perceiving a healthy life and not experiencing any mental distress is one of the culturally transmitted beliefs. With this belief, people want to eliminate or suppress any difficulties and pains they encounter to achieve a good and healthy life, and they avoid personal experiences that disturb them (Zettle, 2007). However, avoiding these uncomfortable experiences and pain or trying to control them will put the person in a vicious circle where he will experience more distress (Levin & Hayes, 2009). On the other hand, it is emphasized that the person should not be identified with pain, but accept it as it is (Harris, 2009). The individual can only live a value-oriented life when he gets rid of the pressure of pain by accepting it and learns to be involved in life despite the pain (Hayes & Smith, 2005). In ACT, it is vital to focus on experiences rather than just drowning in thoughts through mindfulness techniques. It argues that even if it may be difficult and painful, it is necessary to pay attention and approach the experiences openly and curiously without avoiding them (Hayes et al., 2006).

ACT focuses on experiential avoidance and compelling experiences while increasing psychological flexibility. Increasing psychological flexibility contributes to consciously being in the moment and living a life in line with personal values (Hayes et al., 2006). ACT proposes to use the values on which individuals want to base their lives, as a guide and motivator in the process of change.

ACT assumes that people have the opportunity to find meaning and purpose in life even when they are in pain (Harris, 2009). People try to use the "fix-repair-get rid of" logic in the face of painful inner experiences. However, when they accept that subjective experiences and pains are a part of their personal history, their lives will become richer and gain meaning (Eifert & Forsyth, 2005). According to ACT, a person should discover how to handle these experiences and how to accept them and learn to build his life. ACT asserts that while people try to resist psychological problems and pain, they put their lives on hold and cannot start life over again without alleviating or eliminating the pain they experience (Hayes and Smith, 2005). ACT aims to help people live more meaningful lives. In this context, it encourages people to contact the things they are truly interested in find meaning and develop behavior in this direction (Eifert & Forsyth, 2005).

1.2.1. Philosophical and Theoretical Underpinning of ACT

Functional Conceptualism and Relational Frame Theory are two important concepts from the philosophical and theoretical background of ACT.

1.2.2. Functional Contextualism

Functional conceptualism argues that since psychological events are considered as the actions of the whole organism, actions cannot be separated from the context in which they occur. In the functional contextualism approach, psychological events are viewed as interactions between individuals and the context, defined as both historical (learning history) and situational (antecedents, consequences, verbal rules). In other words, it is thought that analyzing an event is possible by examining the historical background and purpose of that event. For this reason, functional context analysis focuses on the ongoing behavior and the environment in which the behavior occurs (Bach & Moran, 2008). The environment in which

a behavior takes place, before and after the behavior are all taken into account as a part of the context.

Functional contextualism focuses on the ongoing actions that take place in the context, rather than approaching the subject as if examining the parts of a machine. The subject and the environment are in a relationship as a whole (Twohig, 2012). For this reason, it is argued that rather than examining the rightness or wrongness of actions and events, it is necessary to investigate how they operate in the context (Westrup, 2014). According to functional contextualism, each behavior is analyzed by considering the conditions of the context and its purpose in that context (Hayes & Pierson, 2004). In other words, each behavior has a function that needs to be addressed in the context. In this context, thoughts are characterized as functional for a more value-oriented approach (Ruiz, 2010). According to the functional contextualism perspective, actions are beneficial and functional if they are compatible with personal values (Hayes et al., 2004).

Functional contextualism differs from mechanistic approaches, especially in terms of addressing the environment-behavior relationship. Environment and behavior are seen as variables that complement each other rather than being separate from each other. Therefore, in functional contextualism, it is meaningless to examine behavior apart from the context, just like examining the environment without a living creature (Hayes et al., 2012). Separating the problematic behavior from the context will prevent the ability to understand the nature of the main problem and produce solutions (Hayes et al., 2012). In functional contextualism, cases are evaluated holistically and context-oriented rather than mechanistic evaluations for diagnosis. With this approach, psychological events that can be described as negative and irrational are handled with an open and accepting attitude (Hayes, 2004). ACT will be more understandable by considering the assumptions and goals of this philosophical approach. ACT does not handle emotions and thoughts with a mechanical approach. ACT assumes that if emotions and thoughts are evaluated in the context, the relationship with the behavior will be understandable (Hayes et al., 2004).

1.2.3. Relational Frame Theory

Another approach on which ACT bases its theoretical structure is Relational Frame Theory (RFT). RFT is the reference of ACT in the interpretation of human behavior while

examining the relationship of language and cognition with behavior (Hayes, 2004). RFT is a behavior analytical explanation that explains the effect of language and verbal-symbolic behavior processes when individuals try to cope with the compelling thoughts and emotions they experience. RFT states that humans are the only creatures capable of responding to arbitrary relationships without the need for direct learning. This ability forms the basis of language and cognition. Language is a way of forming and responding to symbolic relationships. It provides meanings for objects and events that may lead to change in their effect. Thus, the language has potential to make everything a source of pain and increase the pain experienced. As a result, human behavior can be affected when language is an active factor (Hayes et al., 2001). RFT suggests that attempts to focus on the functions of events should be appropriate to the nature of language and cognition (Ruiz, 2010).

According to RFT, language and cognition are learning-based and contextually controllable skills. These skills enable people to establish mutual and combinational relationships between events and to reach a conclusion by transforming the functions of relevant events (Levin & Hayes, 2009). People whose cognitive development progresses normally acquire language skills and establish connections between objects and words. Starting from childhood, when language skills begin to be acquired, objects in the environment are named and the two-way relationship between the word and the object is learned. In other words, when the word is heard or thought, the object appears in the mind, and when the object is seen, the word comes to mind. For example, when a person learns the word 'lemon', a yellow lemon fruit will appear in his mind when he hears the word 'lemon'. He will also be able to say the word 'lemon' when he sees a lemon (Pearson et al., 2010).

According to RFT, the basis of language and cognition lies in the ability to learn to establish relationships between events. Nonrandom stimulus relationships are defined according to the formal properties of associated events. Human beings evaluate what they learn not only formally but also according to the context. For this reason, for human beings, the size or smallness of something also expresses some abstract meanings such as value, rank, and so on in addition to formal meaning (Hayes, 2004).

Relational learning has three basic features. First of all, many events show bidirectionality. If one learns that A is somehow related to B in a context, this will then require B to be related to A in this context (Kingston, 2008). Second, some events show

combinational requirements. For example, if someone learned in a particular context that A is related to B and B is related to C, it would require a similar reciprocal relationship between A and C. Finally, some relationships allow the functions of the stimulus to be transformed between other related stimuli. Relational reactions considered within the scope of these three features are defined as relational framing (Hayes, 2004). According to the RFT perspective, relational framing constitutes one of the cornerstones of human language and cognition processes (Hayes & Hayes, 1989).

What makes relational framing clinically meaningful is that the meaning of an event may differ for people. ACT accepts the ways of thinking as the lenses through which a person looks at the world. These lenses determine the pattern in a way that a person evaluates the self and interprets experiences. The point that needs to be emphasized is that situations should not be considered simply with the formal features, but with the verbal/cognitive factors associated with the situation (Hayes, 2004). In ACT-based therapies, the person is helped to recognize these lenses and how they affect the language (Hayes & Smith, 2005).

There are two distinctive features in relational framing: relational context and functional context. Relational context determines how and when relationships can be established while functional context determines which functions will be transformed according to the relational network. In other words, the relational context determines what people think, the functional context determines the psychological impact of what people think. Because relational framing is learned and arbitrarily adaptable, it is not possible to prevent unhelpful relationships from being formed by controlling the relational context. When learning occurs through association, it affects the perspective and interpretation of new experiences, even if it is not expressed externally. Therefore, although unwanted schemes are effective and permanent, it is not easy to reconstruct the cognitive network (Hayes et al., 2013). Relational framings are learned behavioral processes that organize human experiences. They can pave the way for the formation of psychopathology when verbal processes are decisive in regulating behavior and when they cause to suffer and intensify this pain regardless of the existing characteristics of the environment (Bolderston, 2013). For this reason, these processes are addressed in therapy and the functions of some relational framings are reconstructed when necessary (Hayes et al., 2004).

1.2.4. Basic Concepts of Acceptance and Commitment Therapy

Certain concepts form the building blocks of ACT. It is deemed essential to focus on these concepts to better understand the therapy approach. These concepts are creative hopelessness, psychological flexibility, and psychological inflexibility.

Creative Hopelessness

Generally, various actions and ways are attempted to get rid of disturbing feelings, thoughts, and memories. It is thought that the problems can be solved only when these negative experiences are removed. It is common to believe that only if undesirable feelings, thoughts, and memories are removed from life, life will be better. However, the main problem is the actions taken to eliminate these experiences since that they increase the intensity and duration of unwanted emotions and thoughts (Walser & Westrup, 2007). People can produce new ways after they see that the effort to change negative experiences is useless which is called "creative hopelessness". The word 'hopelessness' in the concept is the hopelessness of efforts to control the events in the past and problems as well as to change the emotions, thoughts, and feelings. The word 'hopelessness' should not be associated with the current mood or possible future. Moreover, the concept of 'creativity' in the concept means being creative in producing new solutions (Hayes et al., 2004).

The short- and long-term usefulness of which feelings and thoughts people have tried to change, which experiences they have tried to avoid, and what they have done so far are discussed (Zettle, 2007). For interventions to be effective in ACT, "creative hopelessness interventions" are used. Most of the time, people come to therapy after trying many ways to get rid of the difficult situation they are in. The person is motivated to start a new process by becoming aware of the useless strategies and their effects (Ciarrochi & Bailey, 2008). While creative hopelessness is addressed in therapy, the experiential avoidance methods used by the person are also recognized and evaluated. Individuals try to control situations over which they have little or no control and try to avoid unpleasant experiences. However, this attempt results in decreased psychological flexibility. Decreased psychological flexibility harms the ability to take actions consistent with personal values (Bach & Moran, 2008). Creative hopelessness will increase willingness to try new solutions by raising awareness that past attempts and experiential avoidance are not and will not work (Eifert & Forsyth, 2005).

Psychological Flexibility

Psychological flexibility refers to the ability to adapt behavior in the face of emerging conditions by benefiting from here-and-now experience (Hayes et al., 2006). Psychological flexibility is the ability to adapt one's behavior in line with personal values in challenging situations, benefiting from experience in the here and now (Hayes et al., 2006). Psychological flexibility means being able to respond to the demands of the new environment in a new way. In other words, it involves being able to change old behaviors in some contexts and maintaining the same behaviors in some other contexts (Hayes et al., 2004). Individuals can be said to have psychological flexibility if they can act according to these new conditions, requirements, and difficulties in line with personal values (Bach & Moran, 2008). It is predicted that as the skills of awareness, being open to experiences, and acting according to values are increased, a better life can be lived, since that the problems and difficulties inevitably encountered in life will be overcomed more effectively (Bolderston, 2013).

Six core principles provide psychological flexibility in the ACT model: contact with the present moment, values, committed action, self-as-context, defusion, and acceptance. While ACT considers these six elements as the six faces of a prism, it considers the prism as psychological flexibility. Each of these fundamental processes is interconnected in so many ways that it is not possible to isolate or remove any of them. This model of ACT, consisting of six core processes, is called the "flexible hexagon model" (Figure 1). Since the individual will gain psychological flexibility after each of these processes is addressed, the model is also called the "psychological flexibility model" (Hayes et al., 2004). Therefore, the purpose of ACT is to increase the psychological flexibility of the person to cope with the difficulties of life more effectively (Strosahl et al., 2004). Intervention approaches to psychopathology are also shaped through these processes.

In this context, the primary goal of ACT is to increase psychological flexibility. The psychopathology approach of therapy is described through the hexagonal model. Through the hexagonal model, the solutions to the problem that have not worked so far are evaluated and awareness is gained regarding the limited behavioral repertoire. In addition, determining the psychological areas that will help in gaining psychological flexibility is defined (Bach & Moran, 2008). In ACT, rather than solving problems, it is aimed to develop psychological

flexibility and get in touch with personal problem-solving resources. If these skills are insufficient, new problem-solving skills are taught (Levin & Hayes, 2009). To provide psychological flexibility, metaphors, experiential exercises, exposure exercises, and paradoxes are used in the ACT. With these exercises, people begin to distance themselves from their thoughts and experience cognitive dissociation. For example, experiential exercises such as giving a name to the thought, singing the thought as a song, or physicalizing it are used to provide cognitive dissociation (Stoddard & Afari, 2014). Hence exercises are useful to reinforce acting in line with values in situations (Ruiz, 2010).

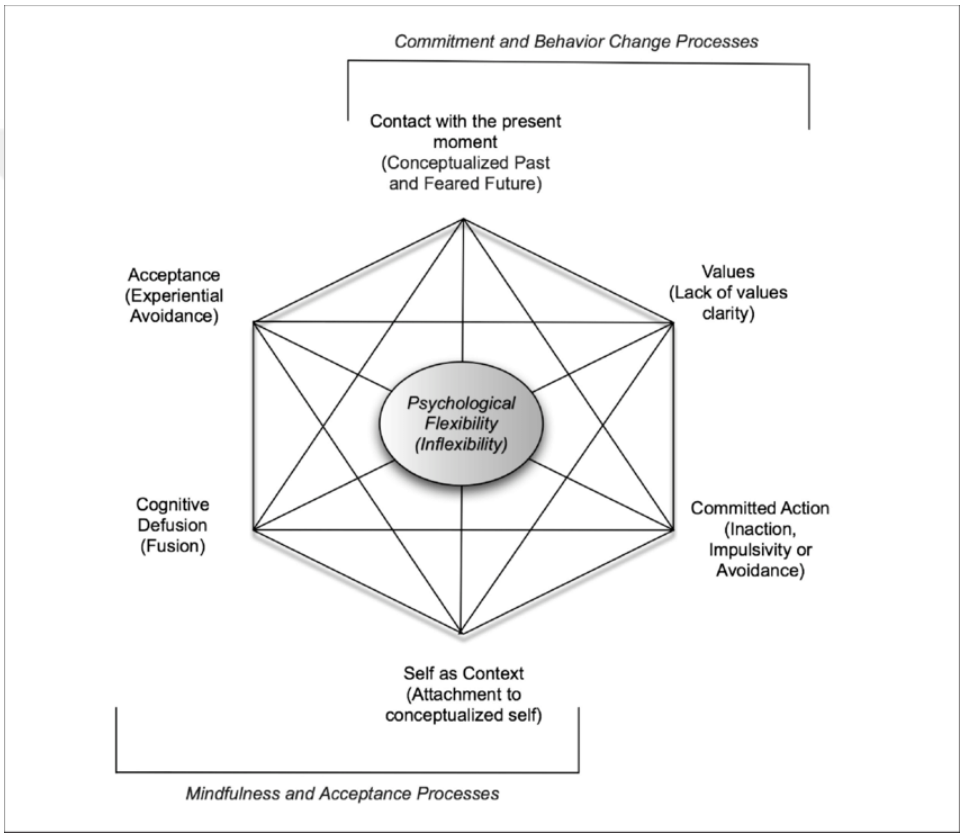


Figure 1. The hexaflex model of ACT

Psychological Inflexibility

Psychological inflexibility is the opposite of the concept of psychological flexibility. Psychological inflexibility refers to the inability to regulate behavior in favor of the self, the inability to change the behavior when needed, the inability to continue when needed, and thus the inability to achieve the desired results (Hayes et al., 2004). Certain processes that cause individuals to lose psychological flexibility are experiential avoidance, conceptualized

past and feared future, dependence on the contextual self, unawareness of values, cognitive fusion, and avoidance. Each of these concepts emerges as the opposite of structures that construct psychological flexibility: acceptance versus experiential avoidance, contact with the present moment versus conceptualized past and feared future, values versus lack of values clarity, committed action versus inaction impulsivity or avoidance, self-as-context versus attachment to the conceptualized self and cognitive defusion versus cognitive fusion ACT, states that the basic pathological problems are caused by psychological inflexibility. Life contains many difficult experiences and pains. It is emphasized that trying to avoid the pain causes exaggeration rather than elimination of the pain (Hayes et al., 1999). Fundamental pathological problems are caused by not accepting pain as they are, allocating all energy to the solution of the problem without being aware of the present focusing on values, and deviating from the values. According to the ACT perspective, distress and psychopathology are the result of the limiting effect of language on the behavioral repertoire in two basic areas: cognitive integration and experiential avoidance. These two processes are directly related to psychological inflexibility (Hayes et al., 2004). To better understand the approach to psychopathology, it is necessary to consider six basic dimensions that cause psychological inflexibility.

One of the conditions thought to cause psychological inflexibility and thus psychopathology is experiential avoidance. Experiential avoidance, which occurs at the point where acceptance is not achieved, refers to the attempt to avoid events, emotions, thoughts, and behaviors that are thought to result in psychological harm. Those who believe that healthy people do not experience psychological pain such as stress, depression, and traumatic memories wish to have no negative emotions, thoughts feelings, and any pain. For this reason, possible painful experiences led to avoidance (Hayes et al., 2004). Another dimension of psychological rigidity is cognitive fusion. Cognitive fusion refers to behaviors being guided by the verbal content of thoughts rather than experiences (Bach & Moran, 2008). Sometimes, a person fuses the event with thoughts so much that he cannot distinguish that this is an subjective interpretation of the event. For example, the person does not recognize the anxiety about the future as a result of personal interpretation but accepts anxious thoughts as things that will happen (Hayes et al., 2004). When an individual fuses with a thought, avoidance of negative thoughts that will reveal previous attribution occurs. Sometimes, to avoid this thought, individuals lose behavioral flexibility because they stay away from areas that are valuable and meaningful (Bach & Moran, 2008). Another area that

feeds ACT's approach to psychopathology is the conceptualized past and feared future, which expresses the opposite of contact with the present. Cognitive fusion and experiential avoidance reduce here-and-now experiences (Harris, 2009). Sometimes people reduce contact with the present to avoid painful experiences, sometimes they focus on the past and sometimes the future. However, decreasing contact with the present poses a problem as it leads to psychological inflexibility (Hayes et al., 2013).

Another area that causes psychological inflexibility is attachment to the conceptualized self. The conceptualized self refers to the verbal content that the individual uses to define and describe himself. The conceptualized self includes objective data such as age, gender, marital status, and profession, as well as definitions of roles, relationships, strengths and weaknesses, likes and dislikes, and hopes and dreams (Harris, 2009). The conceptualized self itself does not pose a problem; the real problem is the loss of psychological flexibility by becoming attached to the conceptualized self. When an individual becomes attached to the conceptualized self, he latches on definitions that are no longer valid, thus further increasing distress (Hayes et al., 2013).

Another aspect that causes pathology is the lack of values clarity. Sometimes people have not clarified personal values or cannot understand that the behavior is guided by values. If people become aware of values, make them clear, and strengthen the basis of actions, their motivation to act increases (Bolderston, 2013). ACT aims to influence behavior by values rather than by cognitive fusion or experiential avoidance. However, values must not be perceived as fixed rigid rules (Hayes et al., 2013). Another dimension is insistence on inaction, impulsivity, and avoidance. These behaviors are fueled by experiential avoidance motivation rather than personal values. These actions are impulsive, reactive, and automatic rather than conscious and personal goal-oriented actions. These behaviors distract the person from conscious awareness and a value-oriented life. These useless behaviors do not contribute to life-enriching, and even make life more difficult (Harris, 2009). In this context, in ACT case conceptualizations, it is tried to understand what the individuals do too little or too much, what they do under the title of experiential avoidance and inappropriate behaviors (Bach & Moran, 2008).

1.2.5. ACT Model of Psychological Flexibility

Acceptance

Acceptance is being able to show a flexible attitude towards what is experienced without trying to change or abolish whatever is experienced, whether it is painful or not. (Hayes & Fletcher, 2005). Acceptance refers to opening oneself to experiences by giving oneself a space to exist, rather than struggling with it that could be a feeling, a thought, or an impulse. Acceptance is aimed not at loving or passively accepting the inner experiences that are undesirable to experience but at reducing the effect of these painful feelings on behaviors to support living a meaningful life. This concept can often be misunderstood and may initially attract a reaction. Acceptance does not express a feeling such as giving in to troubles, problems, or painful experiences, starting to feel good emotions, or forgiving (Walser & Westrup, 2007).

In ACT, it is not advocated that all emotion and thought should be accepted in every condition and situation. ACT advocates the necessity of accepting when the methods used to control emotions and thoughts reduce the quality of life. According to ACT, as people spend most of the time by avoiding painful inner experiences and trying to get rid of them, they lose contact with personal values over time (Gordon & Borushok, 2017). Acceptance of psychological distress is only necessary if the individual avoids distress in a way that prevents from acting in line with personal values. Otherwise, it does not always mean that all psychological problems are approved or accepted. For this reason, it is thought that it would be more accurate to conceive of acceptance as the act of approaching avoidant stimuli to act by values (Blackledge & Barnes-Holmes, 2009). As a result, it is thought that there is no problem if one can live a life based on values while controlling emotions and thoughts (Harris, 2009).

If the ability to accept emotions that people avoid experiencing such as anxiety, loneliness, and sadness, the person will be able to stay with that emotion, make space for it without shifting the attention to other things, and thus improve emotion regulation skills. Acceptance refers to the things a person can and/or need to change. It is a process that involves getting to know oneself better by distinguishing the things that one cannot change and/or does not need to change (Eifert & Forsyth, 2005). To develop the ability to accept,

exercises involving bodily and emotional awareness, practices of concretization of emotion, and practices about what emotion means to the person are used in therapy.

Contact with the Present Moment

Most of the time, attention is shifted either to the past or to the future. Present-moment awareness focuses on the inner world and the physical environment by being in the moment rather than thoughts about the past or the future. Contact with the present means being here and now, conscious and aware of what is currently being experienced, without getting lost in thoughts. It also includes the flexibility to pay attention to both the internal, psychological world and the external, physical world simultaneously (Harris, 2009). Conscious awareness, which expresses contact with the present moment, refers to the evaluation of the life and world according to experiences in the present, rather than verbalization in the mind (Bach & Moran, 2008).

When the mind evaluates memories, it creates various scenarios about what happened, what should happen, and what should be escaped to avoid similar troubles. However, over time, these evaluation processes become increasingly prolonged and intensified, and may limit the functionality (Bolderston, 2013). Similarly, concerns about the future may cause despair and disaster scenarios, such as the bad things that happened in the past will reoccur in the future and nothing will change. Even though the future is unknown and cannot be fully controlled, and the past has already happened, people worry about the past or the future while missing the things they are experiencing today. However, being able to observe the emotions, thoughts, and feelings experienced in the present helps each moment gain a new meaning and becomes an antidote for troubles (Walser & Westrup, 2007).

ACT therapists try to ensure the awareness of the moment because it is believed that it is more functional to focus on what the client is experiencing in the present rather than resorting to interpretations of the client's past behavior and assumptions about the future (Blackledge & Barnes-Holmes, 2009). For this reason, various exercises such as breathing exercises and spontaneity in daily life are used to help people get in touch with the moment (Harris, 2009). The aim is to increase the awareness of the ground and sensations (sound, image, smell, texture, etc.) as well as the awareness of thoughts and feelings (Hayes &

Fletcher, 2005). Being able to experience what is happening with conscious awareness provides the opportunity to handle feelings and thoughts as they are without attaching connotations, to react more freely, and to make choices in line with values (Walser & Westrup, 2007).

Values

Values are principles that motivate and guide people to take action throughout life. Values express the individual's choices about how he wants to direct his life, what he wants to do in life, what he wants to represent, and how he wants to act accordingly (Hayes et al., 1999). 'What are you living for?' or 'What kind of person do we want to be like?' or 'What do you want to realize?' Values are the wishes that are felt in hearts while answering all these questions (Harris, 2019). Values are the desired qualities in actions and are defined as "chosen preferred life directions". In other words, it expresses how people want to behave (Harris, 2009). The values express that people want to guide the behavior by declaring the compass to live a meaningful life (Hayes et al., 1999). Values do not express the goals to be achieved, but rather the principles that guide behaviors towards achieving the goals, that is, the individual's desires, dreams, and motivation sources (Blackledge & Barnes-Holmes, 2009). While values are guidelines on how life is desired to be lived, goals mean things that are desired to be achieved and completed (Hayes et al., 1999). The metaphor of "compass" or "moving towards a direction" is used to describe values. Even if the goals determined in line with the values are achieved, the value does not end and motivates determining new actions. In this respect, values express the determination to be on the path, not a destination to be reached (Walser & Westrup, 2007).

Determining the direction a person will follow makes it easier for them to decide what kind of choices will make and how will proceed. On the contrary, a person who is concerned about where not to go constantly tries to escape from something and constantly limits himself (Bach & Moran, 2008). With the effect of experiential avoidance and cognitive defusion, individuals direct their behaviors within the framework of a narrow and rigid behavioral repertoire, and their values lose the clarity over time. Therefore, with ACT, a person determines personal values in many areas and realizes behavioral goals in line with these values (Harris, 2009). Ten areas are identified during the clarification of values: close relationships, parenting, family relationships, social relationships, work, leisure, citizenship,

personal development, health, and spirituality (Dahl & Lundgren, 2006). Before taking action and showing decisive behavior, which is the most important part, values are clarified, and goals are determined accordingly. Values are orientations that are specific to each person and determined by the unique personal story. Since there are no ideal standards set for values, personal values are not open to judgment (Bach & Moran, 2008).

Committed Action

Committed action expresses actions that are consistent with personal values or behavioral changes in this direction. It refers to the effective but flexible actions determined in the short, medium, and long-term leading with values in a certain area of life (Hayes & Fletcher, 2005). Deciding to act on values requires determining the behavioral processes to be carried out accordingly (Bolderston, 2013). Planning certain behaviors to be performed in specific contexts provides a road map for taking decisive, value-oriented actions. On the other hand, taking determined actions means accepting the disturbing feelings and thoughts that will be encountered in this process. It also means willingness to handle them together with ACT strategies such as dissociating from them, contacting the present moment, and contextual self (Blackledge & Barnes-Holmes, 2009).

Another significant factor in the sustainability of determined action is the ability to determine various goals that are compatible with personal values in a way that will facilitate its implementation (Walser & Westrup, 2007). Stable behaviors create a new environment-behavior relationship that allows acting in a new way in the old environment or exhibiting the behaviors developed in a new environment. This new environment-behavior relationship also supports the development of psychological flexibility (Zettle, 2007).

Self-as-context

There are three basic perceptions of the self: the conceptualized (contextual, semantic) self, the functioning (aware) self, and the contextual self. Firstly, the conceptualized self refers to the definitions and evaluations of the self (Bach & Moran, 2008). The question "How do you define yourself" provides information about the conceptual self. The way a person conceptualizes the self allows one to evaluate what positive or negative thoughts are associated with the self and how these affect psychological

flexibility (Zettle, 2007). Secondly, the functioning self refers to the capacity to be constantly aware of psychological reactions and experiences (Bach & Moran, 2008). Functioning self refers to the individual's perception of the self at that moment and the awareness of emotions, thoughts, and feelings. Expressions such as "I'm anxious, my stomach hurts" are considered within the scope of this type of self. In the functioning self, individuals live in the past or the future rather than living here and now and experiencing events in this context, and interpret current experiences from this perspective (Zettle, 2007).

The last of the self-awareness processes is the contextual self. This concept, which constitutes one of the basic components of ACT, is also referred to as the observing self in the literature (Hayes et al., 1999). It is the "observing self" that always presents and notices the thinking, feeling, and sensing as if watching from the outside (Hayes & Fletcher, 2005). To illustrate, the body, thoughts, or feelings may change over time but while all these changes are happening, the "me" who both notice the change and observe the whole process never changes (Harris, 2019). Contextual self is defined as pure awareness, which refers to the awareness of notices. Even though events, places, times, and people change over time, the “self" does not change. This perspective of immutability is explained by the concept of contextual self. Even though many things change in different parts of life, there is a "me" that experiences all these changes but does not change. The contextual self does not mean being neither happy nor angry, neither feeling valued nor envied, neither calm nor agitated. It refers to a higher self that can experience all these changes but is none of them (Blackledge & Barnes-Holmes, 2009). With the contextual self, a person can look at emotions, thoughts, memories, and feelings from a distance and separate from them by observing them and letting them come and go. This contributes to the ability to look at experiences non-judgmentally, without fusing with feelings and thoughts (Kingston, 2008). Realizing that the self is beyond all emotions, thoughts, memories, and sensations will, on the one hand, reduce the pain and suffering, and on the other hand, motivate them to take action in line with values instead of reacting to the emotions and thoughts impulsively (Westrup, 2014). ACT works with self-as-context to make it easier to live according to the values in the discomfort situation (Harris, 2009). With the contextual self, the person can easily make choices appropriate to the situation and values (Flaxman et al., 2011).

Cognitive Defusion

Cognitive defusion refers to the ability to define emotions, thoughts, memories, and feelings as internal experiences rather than evaluating them as truths about the self and the environment. Cognitive defusion can also be described as putting distance between the thought and the person who thinks (Walser & Westrup, 2007). In other words, cognitive defusion states that a person learns to stand back and look at the thoughts, memories, and images from a distance, allowing them to pass through the mind instead of constantly being busy with them or getting stuck on them (Harris, 2009). Even a common word, if associated with experiences, can become a symbol and cause one to feel uncomfortable. Disturbing thoughts can arise at any time, beyond one's control. However, if the person tries to get rid of them or escape from the memories, this repression may result in discomfort and cause constant deal (Hayes & Smith, 2005). Thoughts are not problematic by nature, but reacting impulsively to events combined with the content and meaning of thoughts is problematic. At this point, cognitive defusion is not the process of changing thoughts but changing the relationships with the content (Stoddard & Afari, 2014). When thoughts no longer become just thoughts and they define the person or constitute the truth, cognitive fusion occurs. Therefore, cognitive fusion leads to behavior under the pressure of thought and avoidance of experiences that could be overcome (Bolderston, 2013). Cognitive fusion, which occurs as a by-product of language, results in self-defeating behaviors (Hayes et al., 1999).

ACT aims to ensure that the person does not interfere with the content of thoughts, fuse with thoughts, or lose the awareness of the moment. Thus, the effect of thoughts on behaviors will decrease and the person may take action without the influence of thoughts (Luoma et al., 2017). The purpose of defusion is not to get rid of disturbing feelings and thoughts but to reduce the impact of thoughts on life and support life based on personal values (Harris, 2009). Language-related practices provided in ACT-based therapy. For example, a single parent may often have thoughts such as "I am alone, life is very difficult, I am incapable of managing everything." expressed as "I noticed a thought that life is difficult" or "The mind tells me that I am inadequate". It is ensured that the person distances from the thoughts externalizes it and embodies them with practices. When people stop looking at thoughts as definite rules or facts to be followed, their contact with their values will become stronger and they will be able to act in line with these values (Harris, 2009).

1.2.6. Empirical Support for ACT

The basic processes in ACT such as acceptance and volunteering, cognitive dissociation, and awareness make people more motivated in the therapy. They eliminate failures and reduce the obstacles in front of the client's participation that may arise due to a lack of motivation. During the therapy process, the individual can learn to accept the self and negotiate a commitment toward change based on achievable results. ACT, which uses awareness-based treatment methods, accepts the feelings and thoughts of the individual as a necessary function of psychological adjustment. Therefore, ACT normalizes experiences by focusing on the function of the behavior and reduces the potential stigmatizing which is the effect of negative cognitive schemes (Luoma et al., 2007; Vogel et al., 2007).

Although it has emerged in recent years, many experimental studies have been conducted to provide empirical support for ACT. Many studies show that interventions based on ACT are effective in increasing the functionality of people with psychological and physical problems and improving quality of life and life satisfaction (Forman et al., 2015). ACT is seen as an effective therapeutic approach to help individuals adapt to manage physical and mental pain and overcome other psychological challenges. ACT-based interventions have shown positive results for post-traumatic stress and substance use disorder (Hermann, et al., 2016), depression (Bohlmeijer et al., 2015), anxiety (Brassington et al., 2016; Davies et al., 2015; Fledderus et al., 2013), obsessive-compulsive disorder (Twohig et al., 2015), post-traumatic stress disorder and affective psychotic disorder (Jansen & Morris, 2016), symptom of psychosis (White et al., 2015), borderline personality disorder (Morton et al., 2012), fibromyalgia (Luciano et al., 2014), hypochondria (Eilenberg et al., 2014), stress and burnout (Brinkborg et al., 2011), suicidal ideation (Walser et al., 2015), poor self-control (Forman & Butryn, 2015), self-compassion (Yadavaia et al., 2014), body image dissatisfaction (Pearson, 2009) and partner aggression (Zarling et al., 2015).

Moreover, many studies with chronic patients showed that ACT is effective for the distress caused by pain (Hann & McCracken, 2014), the effort to control pain (Vowles et al., 2014) depressive symptoms, anxiety, and fatigue levels (Bohlmeijer et al., 2011). ACT contributes to improving psychological flexibility and self-management strategies developed against the disease (Graham et al., 2016). It is observed that ACT applied with 168 chronic pain patients provided a statistically significant increase in psychological

flexibility processes such as psychological acceptance, acceptance of pain, mindfulness, and value-based action. It was determined that the increase in the psychological flexibility levels of the individuals led to a decrease in depression, anxiety related to pain, physical and social inadequacy, and pain intensity (McCracken & Gutierrez-Martinez, 2011).

The literature review shows that ACT programs applied to adolescents also revealed the effectiveness of the approach. For example, as a result of the experimental study conducted on a total of 267 samples consisting of 10th and 11th-grade students in Sydney, Australia, ACT, and a positive psychology-oriented mental health program, at the end of the program significant decrease in depression, anxiety and stress symptoms is observed (Burckhardt et al., 2016). In another study, it was found that the eight-week program conducted with 30 high school students diagnosed with body dysphoric disorder was effective in reducing body dissatisfaction and fear of negative evaluation (Habibollahi & Soltanizadeh, 2016). Another ACT-based intervention applied to high school students concluded that the study was effective in reducing the level of academic stress (Prasasstisiwi et al., 2017). On the other hand, in addition to the experimental studies, it is seen that various intervention programs have been developed. A study was conducted to develop a psycho-education program based on ACT as a phone application. In addition, an internet-based intervention program based on ACT has been developed and it has been found that the program is effective in reducing depression, anxiety, and stress scores of university students (Levin et al., 2014).

Benefits of ACT in a Group Format

ACT-based group therapies have also been found to be effective on many different psychological problems. ACT group therapy applied to 21 individuals diagnosed with borderline personality disorder revealed a positive effect on the anxiety and hopelessness levels of the participants (Morton et al., 2012). In another study, which is conducted with 41 participants with various chronic diseases, a program of 20 sessions has a significant positive effect on depression, anxiety, quality of life, self-esteem, and social adjustment (Dewhurst et al., 2015). Another 12-session ACT-oriented psychotherapy conducted with individuals diagnosed with PTSD and affective psychotic disorder contributed to a clinically significant reduction in the symptoms of PTSD and stress levels (Jansen & Morris, 2016). The internet-based six-week remote intervention program shows a significant effect on the stress and

burnout level. Two-month follow-up measurement shows a similar positive effect (Walker, 2017). Moreover, a group of participants who were diagnosed with trichotillomania received eight sessions of ACT-oriented psychotherapy. There is a significant decrease of almost 89% in the behavior of pulling the hair (Crosby et al., 2012). The effect of ACT-focused group therapy on partner aggression is also examined (Zarling et al., 2015). For this purpose, two-hour therapy is applied to the experimental group for 12 weeks. The results show that there is a significant difference between the pretest and posttest, pretest, and follow-up measures of the ACT group. The physical and psychological aggression levels of the participants in the experimental group decreased significantly compared to the control group. Many studies have shown that ACT-based group interventions are effective in reducing social anxiety as well. One of the first studies conducted about social anxiety is the program carried out by Block and Wulfert (2000) with students who have difficulty speaking in front of their friends in the classroom. The findings show that the program is effective in reducing the fear of negative evaluation scores. In another study, after 10 weeks of group therapy with 22 adults, the social anxiety levels of the participants decreased significantly (Ossman et al., 2006). A total of 10 sessions of ACT-oriented psychotherapy was applied to the group of 11 individuals, and it was found that the psychotherapy significantly reduces panic symptoms and avoidant behaviors (Meuret et al., 2012). In a similar study, 12-session group ACT therapy is applied to participants diagnosed with social anxiety. At the end of the program, a significant decrease is observed in the negative evaluation scores of the individuals, and the decrease is still observed after six-months follow-up (Craske et al., 2014).

Empirical Support for ACT Groups for Parents

One of the studies based on ACT and conducted with parents is carried out to contribute to families whose children are diagnosed with autism to cope with the psychological difficulties (Blackledge & Hayes, 2006). In the research, workshops are conducted with 20 parents for two days, lasting 14 hours in total. The workshops include experiential exercises on basic therapeutic processes such as creative hopelessness, cognitive dissociation, acceptance, and values. It is reported that there are significant differences in terms of depression, experiential avoidance, and cognitive identification levels in the pretest, posttest, and follow-up measurement scores. Another example is that ACT-based therapy with parents of children with autism spectrum disorder led to a decrease in parental avoidance and an increase in values-oriented parental behavior and self-compassion. It is

reported that the positive effects of the program persist after the program and, interestingly, the greatest effects are observed after six months (Gould et al., 2018). In a study applied to parents who have a child with a fatal disease, it was found that ACT reduces psychological problems and improves parenting skills and coping skills. This positive effect is also observed at six-month follow-ups (Burke et al., 2014). In other studies, it is reported that ACT can improve aggressive mother-child relationships and reduce hostility and conflicts (Azimifar et al., 2018; Joshanpoush et al., 2017).

Empirical Support for ACT Groups for Divorced Individuals

One of the first ACT-based group interventions applied to divorced individuals was applied by Mikaili and Sharifi (2017) to 40 women who were referred to a psychological counseling center. As a result of the 90-minute intervention for 10 weeks, it was observed that while the depression and anxiety levels decreased, the psychological flexibility level of the experimental group increased significantly compared to the control group (Mikaili & Sharifi, 2017). In another experimental study published in the same year, a 10-week intervention was conducted with 30 divorced women consisting of an experimental and control group. According to the results, the feelings of loneliness of the women in the experimental group decreased significantly, while adjustment after divorce improved significantly (Najjari et al., 2017). Following these studies, in 2019, Ghorbani Amir and his colleagues applied an eight-week ACT-based program to 60 divorced women who were referred to a psychological counseling center. Results show the program is effective in cognitive emotion regulation, resilience, and self-control in the experimental group (Ghorbani Amir et al., 2019). In another ACT intervention conducted with divorced people, 45 participants were divided into an ACT group, a Dialectical Behavioral Therapy (DBT) group, and a control group. According to the results of this study, the psycho-social adjustment and cognitive regulation of the participants who received intervention with ACT increased, and health anxiety decreased. When compared between experimental groups, it is revealed that ACT found as more effective in emotion regulation, but DBT is superior in reducing psycho-social adjustment and health anxiety (Iri et al., 2019). Another remarkable study compares ACT with Compassion-Focused Therapy (CFT) on adjustment after divorce. The 45 participants were divided into two experimental groups and a control group. While ACT interventions last 90 minutes for 10 weeks, CFT interventions consisted of eight sessions of 60 minutes. According to the research findings, both methods are found to be

effective in post-divorce adjustment, and this effect is also detected in a one-month follow-up measurement (Ardeshirzadeh et al., 2021). In another study conducted on divorced people, it was observed that an 8-week ACT-based group intervention reduced the feeling of loneliness by increasing adaptive emotion regulation compared to the control group (Mahmoudpour et al., 2021). In another study conducted on divorced parents, the effects of ACT and Clark Parent Education (CPT) interventions on the emotional-behavioral problems of the child are examined. The intervention consisted of eight sessions of 60 minutes applied to groups with a total of 66 people. The program developed based on ACT, is aimed at strengthening the parent-child relationship. Both the parenting skills group and parent-child relationship group are found to be beneficial in improving the emotional-behavioral problems of the child, developing positive emotions and attitudes towards parents, increasing psychological resilience, and supporting adaptation to the divorce process. However, CPT is found to be more successful, especially in children who are depressed/anxious and have attention problems (Quchani et al., 2021).

Studies of ACT in Türkiye

There is limited research in the Turkish literature about ACT. One of the former studies is a case report by Bal et al. (2015) that resulted in the successful smoking cessation of a person who had been addicted to cigarettes for 35 years. Other ACT studies conducted in our country are about psychological flexibility and the meaning of life (Demirci-Seyrek & Ersanlı, 2017), psychosis treatment (Yıldız, 2018), persecution delusions (Burhan & Şafak, 2019), psychological flexibility in patients with schizophrenia (Cansız et al., 2020), burnout (Toprak et al., 2020) and the effects of traumatic experiences (Gulay & Uysal, 2020).

When the graduate study in the literature is examined, 11 doctoral theses examining the effect of ACT-based therapy programs on various groups and variables are found. Most of them are focused on university students especially the meaning of life (Demirci-Seyrek, 2017), decision-making styles (Ercengiz, 2017), coping competence (Kaya-Aydemir, 2018), and fear of negative evaluation (Ugur, 2018). On the other hand, studies conducted for adolescents deal with social appearance, acceptance, and taking action (Usta, 2017), bullying (Yalnız, 2019), and test anxiety (Yapan, 2021). In addition, functional recovery and motivation of schizophrenia patients (Yıldız, 2019) and anger ruminations and impulsivity

in forensic psychiatry patients (Polat, 2020) are among the thesis topics studied. It is noteworthy that the interventions developed for parents are more limited. The programs developed in this regard are aimed at the psychological resilience, depression, anxiety, stress level, and care burden of parents with children with special needs (Cicek-Gumus, 2020) and the psychological adjustment of mothers and fathers whose children have been diagnosed with autism spectrum disorder (Tumlu, 2021). When the studies conducted in our country were examined, no study benefited from ACT for divorced individuals.

1.3. Emotion Regulation

To clarify the concept of emotion regulation, first, the concept of emotion and then the concept of emotion regulation will be explained under this heading.

1.3.1. Emotion

Before explaining the concept of emotion regulation, it would be convenient to address the concept of emotion. Emotions are a vital factor in many areas of life, such as the ability to cope with problems, social relationships, and physical health, as well as psychological well-being (Lazarus, 1991). Emotions are covert or overt responses to internal or external stimuli, together with experiential, behavioral, and physiological systems. Stimuli that cause the emergence of emotion are the situations that are attributed to physical or cognitive importance which may be related to personal values or goals (Campos et al., 2004; Lazarus, 1991). As the significance a person attaches to the situation increases, the degree of the emotional reaction also escalates (Campos et al., 2004). Emotions have two common characteristics: they arise as a result of the ascribed meaning to a situation, and they have a subjective nature in terms of physiological and behavioral aspects (Gross, 2014). Gross (2014), one of the pioneers of the concept of emotion regulation, explained the emergence of emotions with a chain model. According to the model, the process begins with the exposition of a situation with directed attention to the ongoing situation and continues with making cognitive evaluations, As and result of these cognitive evaluations, finally, an emotional reaction occurs. The emotional response usually brings about a change in the situation and the cycle in the chain continues.

1.3.2. Emotion Regulation

The emergence of the concept of emotion regulation is based on the idea that the person does not just experience the emotions passively but takes an active role in the emotional processes (Campos et al., 2004; McRae & Gross, 2020). With this view, the concept of emotion regulation has begun to be widely researched in the psychology literature. Research shows that emotion regulation has a transformative effect on each process of emotions (attention, cognitive evaluations, physiological consequences, and reaction) (Koole, 2009; Porges, 2007). This power of influence that a person has is called emotional regulation. Emotion regulation is defined as "the process by which individuals influence the emotions they have when they have them, and how they experience and express them" (Gross, 1998). In other words, emotion regulation refers to attempts to stimulate, reduce, prolong, or intensify emotional experience, cognition, response, and/or physiology (Gross & Thompson, 2007).

Emotion regulation is an external and internal effort that expresses the ability to identify, experience, modulate, and express emotion. This effort may be conscious or unconscious, and it may be controlled or automatic (Thompson, 1994). Emotion regulation, like emotions, has a strong effect on many areas such as mental health, physical health, social relations, work performance, and decision-making processes (Koole, 2009). There are two main agreed common features of the emotion regulation process: the activation of a goal that motivates the person to change, and the existence of a regulation strategy in various dynamics of emotion to realize the purpose (Thompson, 1994; Gross, 2014).

Although there are numerous emotion regulation strategies, Gross's emotion regulation process model, which is the most frequently cited in the literature, is taken as the basis for the current study (Gross, 1998). This model is based on the chain model that explains the emergence of emotions, and emotion regulation strategies have been developed in this direction. The situation, attention, cognitive evaluation, and response components in the emotion formation chain are considered potential targets in the model and various strategies are developed for each component. According to the model, emotion regulation strategies are grouped under five main features: situation selection, situation modification, attentional deployment, cognitive change, and response modulation (Gross, 2014).

To elaborate on the features, firstly, situation selection refers to the attempts to increase the likelihood of eliciting a pleasant emotion and or to reduce the likelihood of the emergence of an unpleasant emotion. The situation selection process can be conducted based on inferences about the situation by reference to past experiences, even if the person has not yet encountered a stimulating situation (Gross & Barrett, 2011). Secondly, situation modification refers to the changes made to the situation to regulate the emotional effects of the situation. Thirdly, attentional deployment means what the person does to direct attention in the current challenging situation (DeSteno et al., 2013). To give an example to better understand the concepts, if a person chooses to stay at home instead of going to the job interview because of feeling anxious, 'the situation change' is carried out. To reduce the anxiety, if he drinks water to relax during the interview, the "situation modification" is carried out, if he imagines the birthday party he will be with his friends in the evening while waiting for the interview turn the "attentional deployment" is carried out. Cognitive change strategies, which are another emotion regulation strategy, are changing the evaluations of the situation to reduce the negative emotional impact of the situation. These evaluations may be the personal beliefs about the personal coping potential, as well as the thoughts about the situation (Gross & Barrett, 2011). Cognitive evaluation can be affected by personality, personal and social resources, characteristics of the current situation, and many other variables (Weber, 2001). Finally, response change strategies refer to making changes to experiential, behavioral, or physical components to regulate the response to emotion (Gross, 2014). While the first four strategies are classified as antecedent-focused emotion regulation, the last feature, response change strategies, is called response-focused emotion regulation (Gross & Thompson, 2007).

Difficulties in emotional regulation are also effective in the emergence of various mental health problems. Depression, suicidal ideation, substance abuse, anxiety disorders, eating disorders, borderline personality disorder, bipolar disorder, and attention deficit hyperactivity disorder are examples of psychological problems associated with emotion regulation (Broome et al., 2015). Difficulty in emotion regulation is not a problem experienced only by diagnosed people. It can also be seen in people without any diagnosis, and the prevalence of emotion regulation difficulty is found to be 13.9% in the adult sample (Marwaha et al., 2013). Various studies comparing the emotion regulation difficulties of a clinically diagnosed sample and an undiagnosed sample found that the brain activations and symptoms of these two groups are similar when experiencing difficulties (Petrovic et al.,

2016; Soloff et al., 2012; Yang & Raine, 2009). These findings support that difficulty in regulating emotions is a crucial problem on its own, regardless of the pathology.

One of the most frequently focused terms in the literature on emotion regulation is suppression. It is included as one of the response change strategies in the emotion regulation process model (Gross, 2014). Suppression means the attempt to prevent or reduce the expression of the emotion after the emergence of the emotion (Cutuli, 2014). Although in some context, suppression is evaluated as useful and functional by the person, it causes difficulty in regulating emotions in the long term and loses its functionality (Gaynor & Gordon, 2019). Studies show that although suppression may be perceived as advantageous in the short term and depending on the context, it has little effect in reducing the intensity of emotions and physiological arousal in the long term. Preventing the expression of emotion reduces positive emotions and increases negative emotions. Physiologically, suppression increases the activation of the sympathetic nervous system, causing an intensification of cardiovascular disorders and memory problems. Suppression not only harms psychological well-being but also comes up with sociological adaptation problems (Gross & John, 2003). When all this information is brought together, suppression, which is considered a maladaptive emotion regulation method, is frequently used by ones who have difficulty regulating emotions and results in the continuation of the problem (Gross, 2014).

Emotional regulation decreases after divorce (Mahmoudpour et al., 2021). Shaghaghi and Shahfagr (2010) compared single women and divorced women in terms of cognitive emotion regulation and demonstrated that there is a notable difference between divorced women and single women in favor of single women in terms of cognitive emotion regulation. They also associated lower cognitive emotion regulation with higher anxiety and depression in divorced women. Due to the psychological difficulties divorced people experience, they may not be raising awareness and contact with positive and negative emotions leading inability to regulate emotions effectively.

1.4. Depression

Depression is one of the most common mental health problems that reduces the quality of life by damaging psychological, social, and physical well-being. Depression is an affective disorder that may occur because of stressful life events that cannot be overcome,

and sometimes as a result of daily troubles, although it cannot be attributed to a specific cause. World Health Organization estimates that approximately 280 million people worldwide suffer from depression. Although depression can be experienced by anyone, women are more at risk than men. The prevalence of depression in women is 50% higher than in men. The prevalence of depression among all adults has been determined by the World Health Organization as 5%. (WHO, 2024). Depression is defined by the American Psychological Association as:

"*A negative affective state, ranging from unhappiness and discontent to an extreme feeling of sadness, pessimism, and despondency that interferes with daily life. Various physical, cognitive, and social changes also tend to co-occur, including altered eating or sleeping habits, lack of energy or motivation, difficulty concentrating or making decisions, and withdrawal from social activities (American Psychological Association, 2015, p.784)."*

Depression brings psychological, cognitive, and physical symptoms. First, emotional symptoms such as low life energy, excessive guilt and regret, sadness, grief, unhappiness, apathy and reluctance, emptiness, desperation, pessimism, hopelessness, and guilt are frequently observed in people suffering from depression. In addition, cognitive symptoms such as inability to enjoy pleasurable activities, low self-esteem, self-criticism, concentration problems, loss of motivation, negative thoughts about the future, and persistent thoughts of suicide and death are among the most common symptoms. Finally, the most common physical symptoms accompanying depression are undesirable weight change, appetite problems, sleep problems (insomnia or excessive sleeping), fatigue, psychomotor retardation, or agitation (Cevik & Volkan, 1993; Kessler et al., 2005; Stewart-Sandusky, 2016).

Environmental, hormonal, biological, cognitive, and personality factors have an impact on the emergence of depression. Depression can be seen in people of all ages and socioeconomic levels. However, low socioeconomic status increases the risk of depression. In this context, in addition to economic inadequacy, negative characteristics of the psychosocial environment are also effective in increasing this risk. Environmental factors such as migration, losses, abuse, social attitudes, constant stress, and retirement can also be considered among the predisposing factors for depression. According to the study, which states that four factors increase the risk of depression for women, unemployment, lack of a

close relationship, having more than three children under the age of 14, and loss of mother before age 11 create vulnerability to depression in women (Brown & Harris, 1978). Biological reasons that are effective in the formation of depression are heredity, certain brain structures, neurotransmitters such as serotonin noradrenaline, and neuroendocrine axes. Although there is a genetic predisposition for depression, intense activity in the hypothalamus-pituitary and adrenocortical axis is thought to be effective in the emergence of depression. Depression may also occur because of imbalances in chemical transmission in the brain or the triggering of the biological basis created by some drugs used by environmental factors (Steinberg, 2007).

Beck and his colleagues claim that the basis of depression is based on cognitive impairment. They argue that depression occurs as a result of negative evaluation of the self, the life, and the future. Negative self-evaluation is the attitude of not seeing oneself as worthy of love, not liking oneself, and feeling inadequate and worthless. Negative evaluation of experience refers to seeing experiences as inadequate, unimportant, and worthless. Negative viewing of the future is the attitude of seeing the future as an uncertain, hopeless, and pessimistic point of view (Beck et. al., 1979). Other cognitive psychology studies suggest that depression is associated with attribution to failure. Internal, constant, and global evaluation of failure increases vulnerability to depression. While internal evaluation refers to the person associating the failure with himself, continuous evaluation refers to the belief that the situation will not change, and global evaluation refers to the generalized negative belief that one has failed in everything. It is also suggested that depression occurs because of stressful life events that are evaluated from the perspective of uncontrollable, inevitable, or learned helplessness (Abramson et al., 1978). Finally, personality traits such as perfectionism (Hawley et al., 2006), neuroticism (Coppen & Metalfe, 1965), and dependency (Blatt, 1984) are considered risk factors for depression.

Depression is a mental health problem that affects life in many dimensions, from daily activities to work performance, from relationships to self-perception. Symptoms of depression occur with negative changes in emotions, thoughts, behaviors, and physical functioning (Miller, 2002). Since depression damages psychosocial functionality in many aspects, it leads to economic losses as it is likely to result in decreased work performance and increased work absence (Broadhead et al., 1990). In addition, depression weakens social support mechanisms by causing a deterioration in social adjustment. In this respect,

depression also has a challenging basis for the recovery process. Finally, depression often accompanies alcohol and substance abuse or addiction and constitutes danger by increasing suicidal thoughts and attempts (Lerner et al., 2010).

The most detrimental effect of divorce is psychological problems, particularly anxiety and depression (Daryanani et al., 2016; Glazer et al., 2010). Depression is not limited to instant mood change, but can also affect overall life, motivation, self-confidence, and functionality. Divorced individuals who are depressed may generalize failures in marriage, childcare, or other part of life, resulting in intense helplessness and hopelessness. This attitude seriously reduces productivity and well-being in both personal and professional lives (Beck et al., 1979). In addition, it is seen that divorced parents have common concerns in psychological, economic, and social areas for both them and their children (Daryanani et al., 2016).

When we look at the studies examining the effect of ACT in reducing the widespread devastating effects of depression, one of the early studies was conducted by Zettle and Hayes (1986). In this study, ACT was compared with two different cognitive therapies. In this randomized controlled study, ACT intervention consisted of 12 sessions. Research results revealed that ACT is more effective in reducing depressive symptoms in both posttest and two-month follow-up measurements compared to the other groups. Another study investigating the effect of ACT on depression was conducted by Folke et al. (2012). In this study, the group format of ACT for depression, consisting of one individual session and five group sessions, was applied to people who were unemployed and on long-term sick leave with depression and compared with the usual intervention group. Improvements in depression, quality of life, and general health status of people in the ACT group were observed in both posttest measurements and 18-month follow-up measurements. However, the improvement in depression is moderate. This moderate improvement was associated with long-term unemployment and short duration of treatment. Another study testing the intervention of ACT for depression and anxiety was conducted by Shankar (2014) and consisted of 10 sessions of ACT-based group intervention for people with severe and persistent depression and/or anxiety. A statistically significant difference was detected in depression and anxiety-related symptoms and psychological flexibility in pre- and post-intervention measurements.

1.5. Anxiety

Anxiety is a state of uneasiness felt against a possible threat but without an observable problem situation. Since it is a biological protection system of the body, anxiety is a normal feeling that everyone can experience occasionally. This threat may be against self-esteem, biological integrity, or against emotional integrity (Genctan, 1981). Anxiety differs from fear in that fear is felt against a real danger and that motivates the person to take action. The mental evaluation made when faced with a threat is described as "fear", and the emotional response in this situation is described as "anxiety" (Beck & Emery, 1985). Anxiety may occur as a result of the loss of a loved one, sad or frightening events, financial difficulties, physical illnesses, or alcohol or substance use. Anxiety that occurs in response to a real dangerous stimulus is considered 'normal' if it decreases when the stimulus disappears. Anxiety that remains at a disproportionate level when the risk of the danger is evaluated or that continues even though there is no real danger is called 'pathological'. Psychosomatic symptoms and functional impairments are among the symptoms of pathological anxiety (Ulev, 2014).

Anxiety affects the person in four different aspects: emotional, cognitive, behavioral, and physiological (Beck & Emery, 1985). Examples of emotional symptoms of anxiety include fear, uneasiness, helplessness, tension, alertness, and anger. Cognitive symptoms caused by anxiety are confusion, misperception, difficulty in paying attention, inability to remember, difficulty in thinking objectively, the thought of losing control, and the fear of losing the mind. Anxiety causes many physiological problems such as weakness, sweating, tremors, itching, palpitations, increased blood pressure, feeling of fainting, increased respiratory rate, difficulty breathing, muscle tension, difficulty falling asleep, loss of appetite, abdominal pain, nausea-vomiting, dry mouth, hot and cold flashes. In addition, behavioral symptoms such as escape, avoidance, immobility, speech impairment, coordination problems, and rapid breathing also occur because of anxiety.

Anxiety, which is often perceived as a negative emotion, can positively affect performance and improve quality of life when its creative and constructive aspects are used effectively. Anxiety motivates them to accept and fulfill important responsibilities. It also helps to fulfill the task on time and correctly, which can therefore organize life efficiently. While excessive anxiety can impair functionality, adequate levels of anxiety can provide motivation and productivity. Therefore, addressing anxiety in a balanced and constructive

manner can help individuals achieve success in both their personal and professional lives (Beck & Emery, 1985).

1.6. Stress

Stress is the emotional, motor, cognitive, and psychological reactions to physical or spiritual threats to the organism. Stress is a psychological and physiological process that occurs when one sees oneself as inadequate in coping with an environmental event that is perceived as challenging or threatening (Lazarus & Folkman, 1984). Stress is defined as a specific response that is inevitable and given to ensure adaptation as a result of the processing of the demand that puts pressure on the organism. At this point, stress is seen as a state of tension that threatens the emotions, thoughts, and physical conditions by weakening the ability to cope with challenging experiences (Davis, 1988).

Even while sleeping, a person is under a little stress, because breathing and heartbeat continue even while the one is asleep. Therefore, the absolute end of stress requires not being able to even breathe which means death (Selye, 1973). The source of stress may be emotional, biological, financial, or lifestyle- or age-related. Whether a situation is stressful or not is evaluated by considering individual factors. While the same situation may seem manageable for one, it may be stressful for the other. In addition, although situations that generally cause stress are unpleasant, sometimes pleasant situations can also be described as stressors for the organism. For example, very happy news received unexpectedly may have a stressor effect on the organism (Ulev, 2014).

The organism shows physiological and cognitive responses to stress. Some of the cognitive reactions of stress are attention problems, increasing the activation of short and long-term memory, and problems with identifying the source of stress and trying to find a solution. Physiological reactions also occur with the activation of the sympathetic nervous system so that the organism can return to a state of balance. Physiological reactions that occur when faced with stress are considered "General Adaptation Syndrome". In this process, the autonomic nervous system and endocrine system are activated. Keeping the organism in balance is the function of the sympathetic and parasympathetic nervous systems within the autonomic nervous system. The sympathetic nervous system is activated during

stressful experiences. When the balance is returned after the stress, the parasympathetic nervous system is activated and manages physiological processes (Selye, 1973).

Stress has many physical and emotional behavioral symptoms. Physical problems that develop due to stress are loss of appetite, weight loss, overeating, nausea, diarrhea, constipation, weakness, fatigue, high blood pressure, shortness of breath, tremors in the hands, pain that prevents rest, cramps, frequent headaches, excessive use of painkillers, inability to sleep at night and waking up early. Emotional and behavioral symptoms triggered by stress include extreme anxiety, fear, not being able to enjoy life, perceiving everything as meaningless, getting angry quickly, being irritable, complaining about not having close friends, and panicking when alone or in a closed place. Problems such as difficulty in remembering the activities to do, people and events, inability to focus, and leaving things unfinished are also included. Stress brings with it many psychological or physical disorders such as weakening of the immune system, heart diseases, depression, substance use, and suicide attempts (Lazarus & Folkman, 1984).

Social, economic, and psychological problems faced by single-parent families significantly affect the quality of life, social functionality, and parenting processes (Roman, 2011). Compared to other parents, single parents are at greater psychological risk and experience more depression, anxiety, substance abuse, stressful life events, low self-esteem, social isolation, and lack of emotional support (Daryanani et al., 2016). The psychological problems experienced by single-parent mothers cause the mother-child relationship to weaken and more inconsistent and flexible discipline. Data from a longitudinal study revealed that the detrimental effects of maternal psychological distress on parenting accumulate over time, resulting in long-term damage to positive parenting (Kotchick et al., 2005). An increase in the mother's depressive symptoms affects the children while leading to negative parenting attitudes and behaviors (Barnett et al., 2015). Failure to provide effective parenting harms the child's psychological well-being and exacerbates behavioral and emotional maladjustment (Kotchick et al., 2005). When single-parent mothers perceive that their child's behavior problem is not inconsiderable, they show more depressive symptoms and feel parenting stress more intensely (Glazer et al., 2010).

1.7. Parenting

The concept of parenting refers to the set of methods and behaviors applied by parents or caregivers to support the physical, emotional, social, and intellectual development of children. Parenting is a concept that includes parental attitudes, which include cognitive, emotional, and behavioral elements, and parental behaviors, which express reactions to children's behaviors (Hart et al., 1993). The concept of parental behaviors and parental attitudes appears frequently in the psychology and child development literature. Parental behaviors and attitudes affect children's cognitive, moral, social, and identity development (Kagıtcıbası et al., 2001). Many factors, such as parents' life experiences, personality traits, work and social networks, marital relationships, and the child's character traits, greatly influence how the parent treats the children. Parents' psychological health is also an important factor affecting parenting that should be taken into consideration (Belsky, 1984).

In the literature, parental behaviors are examined under three main concepts: acceptance of the child, autonomy support, and form of control (Schaefer, 1965). To illustrate this concept:

1. Acceptance of the Child: Parents' acceptance of the children contributes positively to the psycho-social development of the children. The love, attention, and support that parents show to their children have a great impact on children's emotional, cognitive, and social development. Parents who accept and are close to their children positively affect children's emotional regulation skills and self-perception and support self-confidence leading to become more successful and happier individuals. Emotional support helps children feel safe, develop a healthy sense of self, and reduce problem behaviors. (Barbera & Harmon 2002).

2. Provide Autonomy: Parental practices that support autonomy encourage and motivate children to make their own decisions, make choices, and be entrepreneurial. The autonomy provided to the child has a structure that encourages them to take initiative and make choices rather than creating pressure to control their behavior. Families that support autonomy value the child's perspective and allow them to solve problems independently. Autonomous parents avoid controlling strategies and strive to develop the child's intrinsic motivation (Joussemet et al., 2008). Parents who do not grant autonomy do not allow the child to organize the environment

independently, but they focus solely on the outcome and use the simplest way to solve the children's problems. Parenting practices that do not support autonomy emphasize obedience and use power against the child to prevent autonomy (Gurland & Grolnick, 2005).

Granting autonomy to children is not a parenting practice without rules or with neglect. The absence of rules is related to permissive parenting rather than positive parenting. Autonomous parenting practices are related to how parents behave according to the child's thoughts and needs (Joussemet et al., 2008). There are four components of autonomy support:

- Providing justifications and explanations for behavioral demands,
- Understanding the child's feelings and thoughts,
- Offering choices to the child and encouraging them to be entrepreneurial,
- Minimizing controlling behaviors (Joussemet et al., 2008).

This dimension of parenting also positively affects the child's school performance and self-regulation skills. In addition, there is a negative relationship between autonomy support and behavioral problems. Children who are supported in autonomy learn the social interactions necessary to become individuals accepted by society and gain a sense of personal identity. Children provided with autonomy by their parents regulate their behaviors to learn social interactions (Barber & Harmon, 2002). The lack of autonomy support not only leads to dependency but also restricts the child's behavioral experiences and social interactions. The concept of restrictive behavior is a combination of psychological control and the absence of autonomy support (Silk et al., 2003).

3. Control Type: Control type is divided into two: psychological control and behavioral control. Psychological control refers to parents overcontrolling their children, criticizing them, being insensitive to children's emotional needs, and using methods such as giving orders, physical punishment, and threats to discipline. Psychological control involves parents' behaviors of constantly monitoring and controlling children's emotions and thoughts. This type of control creates feelings of guilt, shame, and worthlessness in children. Parents inhibit children's autonomy and are insensitive to emotional needs. Psychological control negatively affects children's

well-being, damages relationships with parents, and causes internalization problems and maladjustment (Barber & Harmon, 2002). On the other hand, behavioral control refers to parents observing children's behavior by setting rules and imposing certain limits. This form of control aims to regulate children's socialization and behavior. Parents who use behavioral control clearly and consistently set, express and enforce expectations for children's behavior. Behavioral control helps children develop self-regulation skills, develop behaviors by social norms, and increase academic success (Silk, 2003). Lack of behavioral control is accompanied by guilt, aggression, impulsivity, drug use, and early sexual maturation problems, as well as behavior that violates social norms (Barber & Harmon, 2002).

4. As can be seen, the effects of parenting practices on children are multifaceted, and parents' attitudes and behaviors play an important role in children's development. While positive parental behaviors contribute to children's emotional, cognitive, and social development, negative behaviors can negatively affect the development.

1.7.1. Childcare

"Childcare" is the set of services and supports that are conducted to meet the physical, emotional, and social needs of children. This term is often used for institutions or individuals that provide care for children. Childcare can be provided by a parent or family member or by kindergarten, or nursery (Clark & Waller, 2007). Childcare is a vital building block that supports children's physical, emotional, social, and cognitive development. One of the main purposes of childcare is to protect the safety and health of children. Providing a safe environment includes providing a clean and safe physical environment, protection from injuries, and compliance with health standards (Shaffer, 1996). Another important purpose of childcare is to understand and respond to children's emotional needs to support their emotionally healthy growth. Another purpose of childcare is to help children develop language, cognitive, motor, and social skills through educational and instructional activities appropriate to their age and developmental level (Shaw, 2006).

Emotional stress and psychological problems experienced after divorce can affect parents' childcare, behavior toward children, and interactions with the children. Emotional difficulties such as depression or anxiety can decrease the ability to cope with stress and the

patience of the parent. It may lead them to express negative emotions and behaviors in daily interactions with children. When a parent's mental health deteriorates, the capacity to have healthy and constructive interactions with children may decrease. A decrease in the quality of parent-child interaction may lead to children's emotional needs not being met adequately and thus disruptions in the development of social skills (Cherlin et al., 1998). Mental health problems experienced by parents after divorce may also affect the competence and decision-making processes regarding childcare. For example, parents may have difficulty finding the physical energy and motivation needed to meet their children's needs. In summary, deteriorations in the mental health of parents can negatively affect children's emotional and psychological health (Smith, 2004).

1.7.2. Positive Parenting

The concept of "positive parenting", which has become more widely used in research on child psychology and parenting since the last quarter of the 20th century, represents a significant change in child-rearing methods. This approach is based on the principles of using positive motivation and incentive methods instead of punishment and authoritarian discipline in shaping children's behavior. Positive parenting is a style of parenting that adopts approaches based on cooperation, understanding, and love while raising children. Positive parenting emphasizes the importance of elements such as empathy, understanding, and sensitivity to children's emotional needs in parenting (Gordon, 2008). In the 1990s, especially with the rise of the positive psychology movement, the concept of positive parenting began to attract attention. Similar to positive psychology, positive parenting focuses on developing parents' strengths and potential (Seligman, 2002). It offers a methodology that is sensitive to the child's development and encourages parents to use their talents positively.

Positive parenting adopts an approach that sets limits for children, but these limits are not rigid and immutable and can be flexible in a way that is sensitive to the child's situation and development. In this respect, positive parenting should not be perceived as a "permissive" attitude. Positive parenting, which consists of many principles that will guide interactions with children, includes respectful, supportive, and explanatory communication techniques for children (Durrant, 2014). The main highlights of positive parenting are:

1. Empathy and Understanding: Takes care to understand children's emotional states and approach events from children’s perspective.

2. Open Communication: Establishes open, honest, and respectful communication with children. It takes children's opinions into solving problems and includes them in the decision-making process.

3. Positive Reinforcement: Encourages good behavior by rewarding it. Positive feedback and rewards are used to reinforce and repeat the child's positive behavior.

4. Instructive Discipline: Uses discipline as an opportunity to teach and instruct the child. Rather than punishing, it focuses on teaching and guiding appropriate behavior.

5. Setting Boundaries: Positive parenting emphasizes setting clear boundaries for children, setting boundaries by explaining the reasons for doing so ensures the understanding of children (Seay et al., 2014).

Positive parenting, which brings all these features together, aims to improve children's social skills, empathy skills, and problem-solving abilities, while also providing them with a safe and supportive environment (Siegel & Bryson, 2011). Positive parenting argues that raising children in a supportive and encouraging environment will contribute to healthy social and emotional development. Positive parenting aims to help children develop self-esteem and grow up as self-confident, flexible, and creative individuals. It also teaches parents how to guide children with non-violent, respectful, and solution-oriented methods (Durrant et al., 2014).

A systematic review and meta-analysis study conducted with 102 randomized controlled trials implemented in 33 countries worldwide which evaluated the effects of positive parenting interventions on early cognitive development of children (Prime et al., 2023). The research shows that positive parenting interventions have significant positive effects on children's cognitive development, language, and motor skills. Programs that include responsive care have been found to have greater effects on children's cognitive development, parental knowledge, parenting practices, and parent-child interactions compared to those that do not include responsive care. Additionally, interventions have been found to have a variety of psycho-social benefits for parents and children in low, middle, and high-income countries. The review recommends increasing the implementation of such parenting interventions globally. Various positive parenting programs have been implemented in Türkiye to enable parents to better understand and meet the emotional needs

of children. For example, in a study consisting of 47 parents of children aged 48-72 months with behavioral problems, the effect of the program on the parent-child relationship, parents' discipline methods, and behavioral problems in children is investigated. Both quantitative and qualitative data were collected in the study from the teacher and the parent reports. After the program, more improvements are seen in the parent-child relationship in the children of parents in the experimental group. There is a significant decrease in behavioral problems and parents' dysfunctional discipline methods. In addition, positive changes are detected in issues such as positive parental perception, parental competence, and establishing and implementing family rules. It was determined that the positive effects observed in the study continued in the follow-up tests performed two months later (Şahin, 2021). In another study, the Video-Feedback Intervention Program for Improving Positive Parenting was implemented with 97 parents of children aged 9–33 months (Sumer et al., 2020). It is concluded that the program significantly increases the sensitivity of the mothers in the experimental group and mothers' approaches to sensitive discipline. It is seen that this effect continued in the follow-up measurements made within two-four months. Finally, Sarıot Ertürk (2019) examines the effects of the Positive Parenting Program (3P) on parents of preschool children. The study focuses on the effects on children's problem behaviors and self-regulation skills, as well as the effects on parents' ability to self-regulation. The program also shows significant positive effects on children's self-control skills. However, although the program reduces the severity of children's problem behaviors, the decrease is not found to be statistically significant. After the intervention, a significant improvement is detected in the parents' self-regulation skills. However, no significant improvement is seen in parents' problem-solving skills.

1.7.3. Parenting after Divorce

A divorced parent's mood can significantly impact positive parenting attitudes. Research shows that the psychological challenges experienced by parents in the post-divorce period, such as stress, anxiety, and depression, can have a direct effect on parenting. First, the mood of divorced parents can disturb the ability to be patient and understanding with their children, reducing their sensitivity towards children and causing them to be less supportive (Kelly, 2007). Parents with psychological well-being may be better able to meet and be more sensitive to children's emotional needs, while parents in a bad mood may ignore or have difficulty responding to children's needs. Parents in a state of mind that is not

emotionally challenging tend to use positive parenting techniques, such as encouraging discipline and open communication, more often. In addition, all these consequences that come with the parent's psychological well-being can negatively affect the quality of the parent-child relationship. A parent who has difficulty maintaining psychological well-being can negatively impact children's feelings of trust and connectedness because they show less positive emotional expression in interactions with the children. Therefore, the psychosocial problems experienced by a divorced parent can have negative effects on emotional and social development by harming general well-being and adaptability (Emery, 2016). Parents' attention to emotional needs after divorce not only supports self-well-being but also improves the parents' mood and thus has a positive effect on children. Maintaining psychological well-being comes along with maintaining parenting practices more easily (Strohschein, 2005).

Positive parenting is very central to the psychology of a child whose parents are divorced. Divorce can create stress, anxiety, and feelings of uncertainty in children and can considerably impact children's emotional and psychological well-being. Positive parenting practices can help alleviate negative emotions and support the child's long-term psychological and emotional health (Gordon, 2000). To focus on the helpful effects of positive parenting on the post-divorce process in more detail, the first thing to consider is that it provides a stable environment. Changes after divorce like place of residence, school change, and economic situations can create uncertainty in children. Positive parenting approaches can reduce uncertainty by providing children with consistency and routine. A more stable environment in terms of parenting makes it easier for children to adapt to the post-divorce process. Additionally, children after divorce can often experience feelings of insecurity and rejection. Positive parenting can alleviate these feelings by providing emotional support to children and helping children feel safer. Positive parenting practices can teach children skills to cope with challenges. These skills enable children to be more resilient in the face of challenges which is an inevitable part of life. Finally, positive parenting promotes healthy relationships by increasing open communication and mutual respect between parent and child after divorce (Fabricius & Luecken, 2007).

There are many positive parenting interventions for divorced parents to help them cope with the stress and uncertainty caused by divorce, strengthen their parenting skills, and ensure that children can go through this transition with as little harm as possible. One of the

leading studies implemented in this context, Co-Parenting Therapy helps divorced parents prioritize children's needs and communicate with each other effectively. This therapy focuses on helping parents learn to set healthy boundaries and resolve conflicts in their relationships with each other and their children (Eira Nunes et al., 2021). Another program is the Parenting Apart Program which is designed to enable divorced parents to maintain a consistent and supportive attitude towards children. Programs often teach parents how to play an effective and positive role in children's lives despite living apart (Furstenberg & Nord, 1985). Another alternative intervention for divorced parents is The New Beginnings Program which is developed for divorced mothers to help them cope with the stress of divorce, establish healthy relationships with their children, and manage conflicts effectively (Wolchik et al., 2009). The last prominent program that aims to provide support to parents in situations of family stress is Family Transitions Triple P. This program focuses on parents going through major family transitions, such as divorce, and offers strategies for children to get through this transition as healthily as possible (De Graaf et al., 2008).

2. METHOD

In this section, information about the participants, data collection tools, research design, the procedure of the research, and how the data were analyzed are included. The development of an ACT-based intervention program and the content of the sessions are also illustrated.

2.1. Participants

The population of the research consists of adult women and men who are officially divorced and have at least one child between the ages of 6-18. Because the Alabama Parenting Questionnaire is administered to parents of children between the ages of 6 and 18, parents with younger or older children are not included. Additionally, people who are officially divorced within the last five years were included in the study. Wallerstein and Lewis (2004) examine the long-term effects of divorce, they concluded that while some individuals experienced prolonged effects, the majority adapted to divorce within five years.

A convenient sampling method is used in the study. The announcement of the program was shared on social media (Instagram and WhatsApp). An application form was applied to those who wanted to join the group, and applicants were included in the study group by taking into account the conditions for inclusion criteria. No compensation is provided. The participation is completely voluntary.

The inclusion of the participants are:

1. Officially divorced within 5 years.
2. At least one child between the age of 6-18.
3. The native language is Turkish.

The exclusion criteria are:

1. Being in the process of psychological treatment.
2. Have mental health problems that disturb the attendance of the group processes.
3. Remarried or in the process of remarriage.
4. Being a mental health professional.

To determine whether these criteria are met, the program announcement includes

information that people who meet these criteria can apply. In addition, applicants were asked to fill out a short application form, and information about the inclusion/exclusion criteria was confirmed. People who did not meet the criteria were sent a message and informed that they would not be included in the study because they did not meet the inclusion criteria.

To determine the sample size G-Power analysis was conducted. The power of the research is defined as the possibility of revealing the difference between the two groups. While calculating the sample size, the power of the research and type 1 error parameters should be determined. Studies are generally expected to have at least 80% power (Kul, 2011). In the current study, the power is also accepted as 80%. Finding a difference when there is no difference between the two applications is defined as a type 1 error. The p-value indicates the probability of a Type 1 error. In general, p value below 5% ($p<0.05$) is considered statistically significant. The sample size was calculated based on the effect size of 0.5. Power analysis was conducted using the G Power 3.1 program. It is determined that the minimum sample size of 26 with medium effect size was sufficient for 80% power and 0.05 type 1 error. Random assignment to the experimental and control groups is determined using the SPSS 23.

The status of the study at the stage of selecting participants, assigning them to groups, participating in the intervention program, and completing the measurement processes are explained in Figure 2.

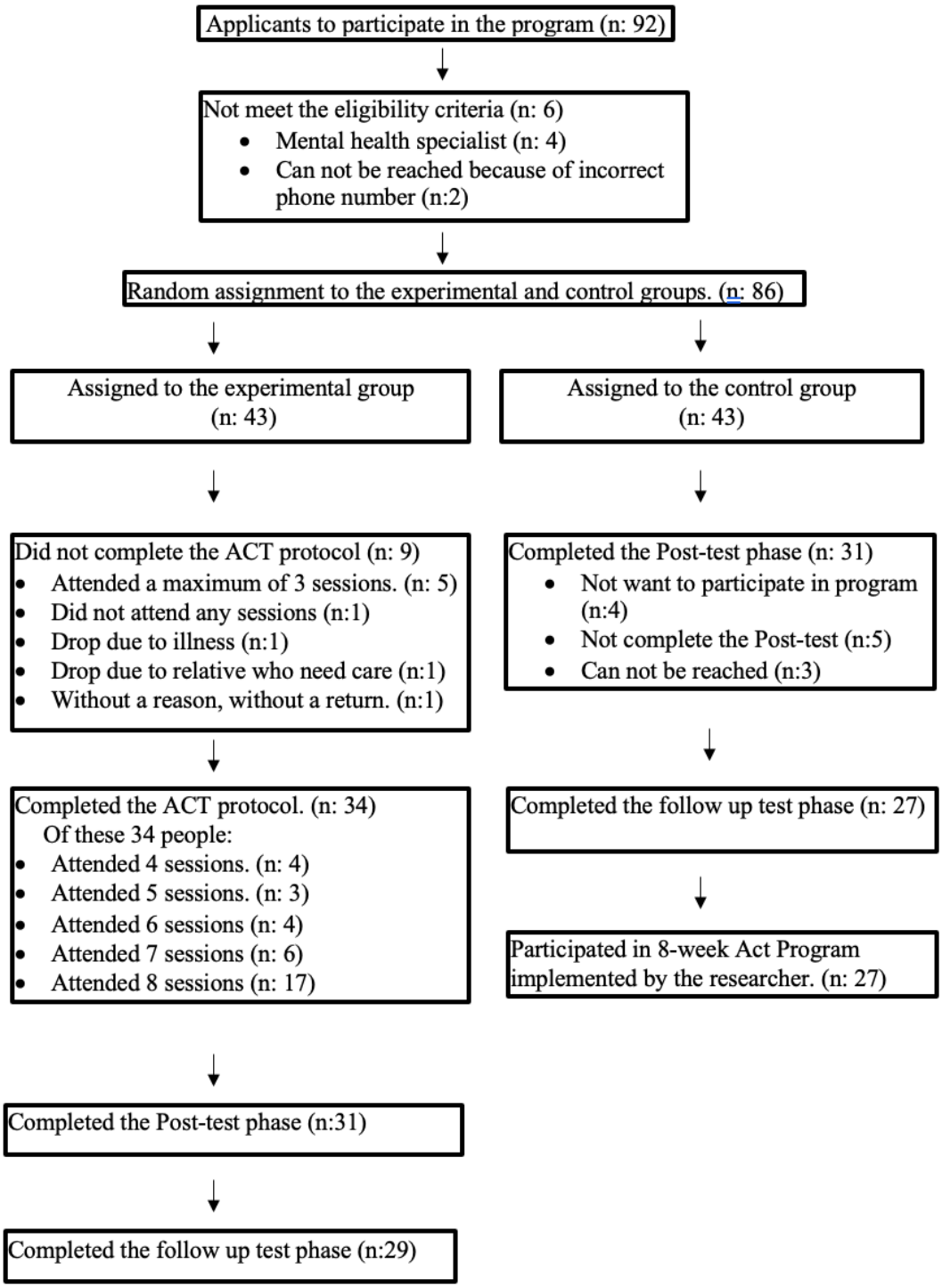


Figure 2. Participation information

As can be seen from Figure 2, 92 people applied to the study after the program announcement spread on social media. 87 of the applicants were women and five of them were men. Applications were evaluated within the framework of inclusion/exclusion criteria and six people were excluded. The remaining participants were randomly assigned to the

groups, by simple random sampling method with SPPS 22.0. Afterward, a form was sent via Google form to the participants in the experimental group to confirm the registration and to choose the appropriate days and hours for the program. The experimental group was divided into three groups of 14, 14, and 15 people, planned for weekday daytime, weekday evening, and weekend evening hours, which they could choose. Since a considerable number of the participants were working, the evening programs were offered to facilitate participation. People in the control group were also informed that they were included in the study and an explanation was given about how the study would proceed. 34 people from the experimental group completed the ACT protocol. Of these, 17 people attended all sessions, six people attended seven sessions, four people attended six sessions, three people attended five sessions and four people attended four sessions. People who attended three or fewer sessions were excluded from the analysis process. Of these 34 people, 31 people completed the posttest administered immediately after the sessions ended. 31 people from the control group completed the posttest phase in parallel with the people in the experimental group. Follow-up measurement was made one month after the application of the posttest. These measurements were completed by 29 people from the experimental group and 27 people from the control group. The 8-week ACT-based program applied to the experimental group started to be implemented with 27 participants from the control group who completed the follow-up measurement.

2.2. Measures

2.2.1. Demographic Form

The demographic form is developed by the researcher to access both personal information about the participants and the answers to the questions that are considered important in the light of the literature. In the form, gender, age, education level, occupation, child information, smoking and alcohol use, psychological support, psychiatric medication, how the divorce decision was made, custody of children and with whom they lived, property sharing after divorce, support mechanisms, individual psychological support and changes in working status are included (Appendix 1).

2.2.2. Psychological Flexibility

The scale was developed by Francis et al. (2016) and adapted to Turkish (Karakus & Akbay, 2020). It consists of 28 items five sub-dimensions: connect with the present moment or mindfulness, acceptance, self-as-context, defusion, committed action, and values. The scale is a 7-point Likert type (1 = strongly disagree; 7 = totally agree). Items 2, 3, 5, 6, 8, 18, 20, 22, 23, 24 and 25 are scored in reverse. High scores reflect high psychological flexibility. Cronbach alpha coefficient of the sub-dimensions is as follows .84 for committed action and values, .59 for dissociation, .73 for self-as-context, .60 for mindfulness, and .72 for acceptance (Appendix 2).

2.2.3. Emotion Regulation Questionnaire

The 10-item scale is developed by Gross and Johns (2003). The ERQ consists of two subscales reappraisal and suppression. The reappraisal dimension has six items, and the suppression dimension has four items. The scale is a 7-point Likert type rated between 1 “strongly disagree” to 7 “strongly agree”. The internal consistency coefficients were between .75 and .82 for reappraisal and between .68 and .76 for suppression across different samples. The ERQ was adapted into Turkish by Ulasan Ozgule (2011) using a 6-point Likert-type scale rated between 1"strongly disagree" to 6 “strongly agree”. The internal consistency coefficients were .78 and .64 for reappraisal and suppression respectively (Appendix 3).

2.2.4. Depression Anxiety Stress Scale

The Depression Anxiety Stress Scale (DASS) was first developed by Lovibond and Lovibond (1995) as a 42-item scale. Henry and Crawford (2005) adapted the scale as a 21-question. The Turkish adaptation of the scale was made by Yılmaz et al. (2017). In the short form, there are seven questions each to measure the dimensions of depression, anxiety, and stress. The first seven questions on the scale are about anxiety, questions between 8-14 are about depression and questions between 15-21 are about stress. The scale has a 4-point Likert-type rating of 0 “not at all suitable for me”, 1 “somewhat suitable for me”, 2 “usually suitable for me”, and 3 “completely suitable for me". Cronbach Alpha value for each sub-

dimension of the adapted scale is .81 for Anxiety, .82 for Depression, and .76 for Stress (Yılmaz et al., 2017) (Appendix 4).

2.2.5. Alabama Parenting Questionnaire

The scale was developed by Frick (1991) and adapted to Turkish by Cekic, Turk, Buga and Hamamcı (2018). The scale was developed with parents who have children between the age of 6-18. The scale examines parental behaviors with five different subscales (Frick et al., 1999). Positive Parenting (PP) measures whether the parent is aware of what the child is doing and whether the child is informed about it; Caring for the Child (CC) measures whether parents spend time with the child, support his hobbies, and help the child in his responsibilities. Poor Parental Monitoring (WPM) measures whether the parent follows and monitors the child; Inconsistent Discipline (ID) measures the inconsistent attitude used by the parent while disciplining their child's behavior; and Punishment by Beating (PB) measures whether the parent uses physical violence to extinguish the child's unwanted behaviors. Childcare (CC) and positive parenting (PP) consist of positive parental behaviors while poor parental monitoring (PPM), inconsistent discipline (ID), and punishment by beating (PB) consist of negative parental behaviors. Consistent with the purpose and scope of the study, only the items related to positive parental behavior consisting of childcare and positive parenting subscales were included in this study. APQ is a 5-point Likert-type data collection tool. None, Almost Nothing, Sometimes, Frequently and Always. While scoring the scale, each item takes values ranging from 1-5. There is no reverse-scored item in the scale. CC subscale consists of items 1, 4, 7, 9, 11, 14, 15, 20, 23, 26; PP subscale consists of items 2, 5, 13, 16, 18, and 27. High scores for the CC and PP sub-dimensions mean that mothers and fathers exhibit more positive behaviors in this regard. For the Turkish version, the Cronbach alpha coefficients for the subscales were 0.77 for caring for the child, and 0.68 for positive parenting (Appendix 5).

2.2.6. Group Intervention Evaluation Form

This measurement tool is developed by the researcher to evaluate the satisfaction of the program and get feedback. The form includes questions about whether the group is beneficial to them, the competence of the group leader, evaluations about the exercises

applied in the sessions, the aspects they like the most and the least, and suggestions about the program (Appendix 6).

2.2.7. The Qualitative Interview Form

The Qualitative Interview Form is a semi-structured form that developed by the researcher in the light of the related literature. The form is used for the Pilot study and development process of the intervention program. The form included questions such as the meaning they attribute to being a divorced person and being a single parent, the changing processes in their lives after the divorce, single parenting experiences, mood changes during the day and coping mechanisms, the recent intense emotions and ways of coping, and the aspects of their lives that they want to change (Appendix 7).

2.3. Research Design

The research is an experimental method that includes quantitative analysis. The research is an experimental study with a randomized control group with pretest, posttest, and one-month follow-up measurement aiming to reveal the effect of 8-week ACT-based Intervention. The participants whose consent was obtained and who were evaluated as suitable to be included in the study were randomly assigned to one of two study conditions by simple random sampling method with SPPS 22.0. Experimental and control groups consisted of three groups. The symbolic view of the model used in the research is given in Table 1.

Table 1. View of the research model

	Pretest	Intervention	Posttest	Follow-up	Interventio n
Experimental Group	M_1	X_1	M_2	M_4	
Control Group	M_1		M_3	M_4	X_1

X_1: 8-week ACT-Based Intervention Program
M_1: Pretest of Experimental and Control Group
M_2: Posttest of Experimental Group
M_3: Posttest of Control Group
M_4: Follow-up Measurement Test of the Experimental and Control Group

The intervention program consisting of 8-week 90-minute sessions is applied to the experimental group after M_1 measurements were taken. After the eight weeks were completed, posttest M_2 and M_3 measurements of the experimental and control groups were conducted. Then, 1 month after the completion of the experimental group intervention, the follow-up M_4 measurement is taken both from the experimental and control groups. Lastly, the same 8-week ACT-based intervention program is applied to the control group after the follow-up measurement is completed. While the independent variable of the study is the ACT-based Intervention Program, the dependent variables are psychological flexibility, emotion regulation, depression, anxiety, stress, and positive parenting behavior.

2.4. Pilot Application

During the pilot study, the intervention program consisted of six weeks with eight participants. In the social media announcement titled "ACT-based Group Therapy for Divorced Parents" made for the pilot study, a total of 39 people, 37 women and two men, stated that they wanted to participate. Among these people, the eight (seven women and one man) were included in the pilot study. Before the implementation of the program, half-hour interviews were held with the participants who wanted to participate in the study to be informed about the divorce process and evaluate the current psycho-social situation of participants. Another aim of the interviews was that people who are perceived to need individual psychological treatment or psychiatric treatment are excluded from the study by referring to related institutional mechanisms. The interviews were held using the Qualitative Interview Form. In these interviews, divorced people were asked the meaning of divorce and single parenthood, the emotional difficulties and sudden ups and downs they experienced during the post-divorce period, the difficulties they experienced in the single parenthood process, and ways to cope with all these difficulties. Asking and understanding this information in depth has been beneficial in getting to know the target audience more closely, developing the content of the program, identifying issues that need to be focused more on during the intervention process, and providing examples that can be given while implementing the program.

During the interviews, one person was excluded from the study because it was determined that she was not officially divorced yet. The sessions started after seven people

filled out the consent form and administered the pretest. After the first session, one of the participants shared the message with the group leader "I felt like I had reopened the notebooks I had closed. The group wasn't good for me. It felt like I was back and thought I was regressing. I felt intense anger again." and she wanted to leave the group. The participant was reminded that she had the right to leave the study at any time without giving a reason and was asked whether she would like to receive personal support. After the participant was excluded from the study, the sessions continued with six people (one male and five female) for 6 weeks with weekly sessions. The average attendance to the sessions was 4.5 sessions. After the pilot study, some changes were made in the intervention program in line with the verbal feedback received from the participants at the last session, the feedback in line with the Group Intervention Evaluation Form, and the observations of the researcher.

The feedback received from the participants in the last session was as follows: “I wish it was every two weeks and lasted longer.”, “It was not boring because it was easy to understand and full of exercises.”, “I did something nice for myself. And I realized what I couldn't do and why I couldn't do it. I was never bored.”, “I tried to follow the exercises. It was sometimes difficult for me because I could not participate regularly from the beginning.”, “The written assignments were useful and gave me insight.” and “It would have been nice to have some notes before or after the sessions.” It was noteworthy that all participants stated that they wanted the program to last longer and that they wanted to continue.

Written feedback was also received from the Pilot group in line with the questions in the post-group evaluation form. In the form, answers to the question "What aspects of the group did you like most?" were: "The group members are willing and sharing about participation, the expression is reinforced with exercises, the harmony of the group, the group leader enlightens us most understandably and is polite, the people in the group enable us to look at it from different perspectives, the friendly and natural environment, the relaxation of the exercises and the group leader reciting by heart by understanding the other side rather than just explaining it". Answers to the question "What aspects of the group did you like least?" were: "Low number of men participants, lack of opportunity to record and re-watch sessions, and irregular attendance". Three of the participants stated that there was nothing they did not like and that everything about the group was good. Answers to the question "Are there things you would like to see changed or done differently? If so, what are

they?" were: "Gender distribution should be more balanced, individual sessions could be held after the groups just as before, and the participation should be sufficient". Four the participants stated that they wanted the program to consist of more sessions.

In line with all feedback, the intervention program was revised to last eight weeks and to include 15 participants in the groups. In addition, the order of the sessions in the program implemented in the pilot study was updated again. For example, while the first sessions started with the values and committed action dimensions of psychological flexibility, it was decided that starting with cognitive defusion and acceptance of feelings would increase the motivation of the participants, and these dimensions were updated by replacing them first.

2.5. Procedure

The draft of the research proposal based on the literature was prepared to be presented for ethical approval. Approval was obtained from the Ethics Committee of Ankara Yıldırım Beyazıt University with the research code of 2023-85 on 10.04.2023. First of all, the program was implemented in a six-week pilot study. After the pilot study, some changes were made to the program, and its final version was given. An announcement titled "ACT-based Group Therapy for Divorced Parents" was made for the application Intervention Program (Appendix 14). The inclusion/exclusion criteria of each person who wanted to be included in the study and completed the consent form were examined. Participants whose applications were approved by the researcher considering the inclusion and exclusion criteria of the study were informed about the importance, purpose, and content of the research. In this context, possible risks and benefits were mentioned for the participants. In addition, they were informed about the process of the study that they could leave the study if they wanted without any excuse, and that everything, they shared during the study would be provided by the researcher by the confidentiality principle. Approved participants were randomly divided into two groups by simple random sampling. Then, the pretest phase of the study was completed for both the experimental and control groups. Afterward, the intervention program was applied to the experimental group consisting of three groups. Sessions were held online once a week for eight weeks.

To encourage participation in the program, it was announced in the first session that the book will be given as a gift to one person to be determined by lottery among those who will participate in the program for eight weeks. To be compatible with the program, Russ Harris's book The Happiness Trap: How to Stop Struggling and Start Living was decided. With casting lots in the last session the books were gifted to three people, one from each group, and sent to their addresses.

Immediately after the sessions were completed, all the scales with online forms were sent to the participants in both the experimental group and the control group to complete the posttest phase. After a month, the participants in the experimental group were contacted again, and finally, the scales were sent again to collect the follow-up phase data. After the follow-up, the control group was invited to the 8-week ACT-based Intervention Program. After the follow-up data were obtained, the analysis of the data was started.

2.6. ACT-Based Group Program

To be able to perform an ACT-based intervention in this study, the researcher completed 42 (forty-two) hours of institutional and practical training approved by the Cognitive Behavioral Psychotherapies Association and the Contextual Sciences and Psychotherapies Association and attended a supervision program. Afterwards, the literature on the research is reviewed. In this direction, the researcher benefits from the related thesis, articles, and also the basic books on the subject such as Easy to Learn Act (Harris, 2019), Happiness Trap (Harris, 2020), The Big Book of ACT Metaphors (Stoddard and Afari, 2014) and ABCs of Human Behavior (Ramnerö & Torneke, 2018). This whole process has increased the researcher's knowledge and equipment regarding the therapy based on ACT. The draft content of the program is also reviewed by the thesis advisor and academicians in the thesis proposal presentation jury and feedback is given. After the pilot application, the program is finalized in line with the verbal and written feedback from the participants and the observations of the researcher. The program was presented to the thesis advisor and two other professors from the department of psychology and serves on the Thesis Monitoring Committee. The program, which was revised in line with the feedback, was also presented with the suggestions of two experts who have clinical experience and actively apply the ACT. The intervention program was revised in line with the written and verbal feedback obtained after the completion of the pilot application.

Intervention program designed to increase psychological flexibility, psychological well-being, emotion regulation skills, and parenting in divorced parents; It is an online program consisting of eight sessions applied once a week, with each session lasting 90 minutes. This program aims to increase the psychological flexibility of the participants, which consists of six dimensions cognitive defusion, acceptance of feelings, self-as-context, present moment awareness, discovering values, and committed action. The developed program is aimed to equip the participants with the skills of acceptance, cognitive dissociation, spontaneity, contact with values, and taking value-oriented actions (Harris, 2019) which are included in the hexagon of psychological flexibility of the ACT.

The general principles of each session are outlined below. To illustrate the general flow of the sessions:

- The previous session is summarized, and any questions are answered.
- The homework given in the previous session is evaluated and discussed.
- The agenda of the current session is explained and gives brief information on the subject.
- ACT interventions are applied to provide direct experience.
- The current topic is summarized.
- Homework is explained and given to be done until the next meeting.
- The session is terminated by receiving feedback from the group members for the last five minutes.

The group rules for the implementation of the ACT-based intervention program are created by the researcher and finalized in line with the opinions of the participants in the first session. While creating these rules, it was considered that the sessions were held online. The goal of the intervention program is to increase the psychological flexibility of divorced parents. However, interventions were made for different purposes in each session. The ACT components contacted in the sessions are listed in Table 2.

Table 2. Content of the 8-week program

Session	Topic	Aim
Session 1	**Introduction, Creative Hopelessness**	• Creating the group • Introduce the program and provide information about the principles of ACT. • To raise awareness of creative hopelessness • To raise awareness of experiential avoidance • To raise awareness that overcontrol is dysfunctional.
Session 2	**Cognitive Defusion**	• To raise awareness about cognitive fusion and its consequences • Raising awareness about negative thoughts • To gain skills in dissociating from thoughts and cognitive defusion
Session 3	**Acceptance of Feelings**	• Accepting negative experiences rather than preventing them • Increasing the ability to accept emotions
Session 4	**Self-as-context**	• Developing awareness of the observing self. • Connecting with the self, regardless of emotions and thoughts
Session 5	**Present Moment Awareness**	• To raise awareness of being in the moment • Developing conscious awareness • Developing the flexibility to pay attention to internal and external experiences
Session 6	**Discovering Values**	• Gaining awareness of values • Determining personal values and increasing contact with values
Session 7	**Committed Action**	• Being able to determine actions in line with values • To gain the ability to take action in line with values and to sustain the action decisively.
Session 8	**Closing**	• To summarize the issues studied in the group in the context of ACT • Receiving feedback from participants about the sessions

The content for each session and the exercises applied within the scope of this content are listed in Table 3.

Table 3. Flow of the 8-week program

Session	Topic	Content
Session 1	**Introduction, Creative Hopelessness**	• Meeting group members • Information about the program and ACT • Determination of group rules • Determination of individual goals of group members • *Magic Wand Metaphor* • Introducing the concept of creative hopelessness • *Metaphor of Fighting in the Swamp*
Session 2	**Cognitive Defusion**	• Awareness of thoughts • *Exercise: Desperate Parrot* • Realizing that thoughts have no control over actions • *Exercise: I Can't Raise My Arm* • Psycho-education on the nature of negative thoughts • Recognizing the negative impact of merging with thoughts • *Exercise:* Hands as Thoughts • Experience dissociation skills from thoughts • *Exercise: I Have a Thought* • *Exercise: Leaves in the Stream*
Session 3	**Acceptance of Feelings**	• The ability to be open to unpleasant feelings and thoughts and to make space for their presence. • *Exercise: Acceptance of Emotions Exercise* • Raising awareness of negative emotions • *Psycho-education* • Raising awareness about acceptance • *Monsters on Board Event*
Session 4	**Self-as-context**	• Awareness of the observing self • *Sky and Weather Metaphor* • *Chessboard Metaphor* • Connecting with the observing self. • *Exercise: Here Go Your Thoughts* • *Exercise: Observing Self*
Session 5	**Present Moment Awareness**	• Gaining the ability to connect with the present by paying attention to the external and internal world. • *Exercise: Self-awareness with Breathing* • *Mindful Eating Exercise* • *Exercise: Listen-Feel-Notice* • Recognizing the negative consequences of losing contact with the present moment • *Exercise: Take Your Mind With You*
Session 6	**Discovering Values**	• Awareness of values • *Exercise: Compass Metaphor* • Determining personal values • *Exercise: 80th Birthday Event* • *Exercise:Garden of Values Exercise* • *Exercise:Ability to Find Values in Unpleasant Activities*

Table 3. (continue)

Session 7	**Committed Action**	• Recognizing the values behind unpleasant thoughts • *Exercise: Litter Box Exercise* • Distinguishing values and goals • *Exercise: Goals and Values Exercise* • Determining the actions that people can take in their daily lives in line with values • *Exercise: Work on Determining Value-Oriented Goals* • *Exercise: Leave Valuable Traces on Your Life Exercise* • Recognizing and overcoming internal and external obstacles to value-oriented actions • *Exercise: Passengers on the Bus Event* • *Exercise: Reasoning Machine Metaphor*
Session 8	**Closing**	• Summary of sessions • *Exercise:Flexible Hexagon* • *Exercise: Unwanted Party Guest Metaphor* • Acknowledgments and Closing • Application of the Sessions Evaluation Form • Application of posttest

2.7. Data Analysis

The data obtained from this research were evaluated in a computer program. IBM SPSS (Statistical Package for Social Sciences) 23 for Windows program was used to analyze the data. Graphs, tables, and figures were drawn using SPSS and Excel programs. The results obtained from the analyses were evaluated according to the 95% confidence interval and the significance value $p < 0.05$.

During the data analysis phase, to decide on the parametric or nonparametric tests to be used, it was first analyzed whether the scores received from the pretest, posttest, and follow-up measurements of the participants in the experimental and control groups met the basic expectations of parametric tests. To use parametric tests, the data must be normally distributed and homogeneous (Cohen & Manion, 1994). To determine whether these conditions are met, the first condition required for the use of parametric tests is that the measurement results of the dependent variable have a normal distribution. When the number of participants is less than 30, the normal distribution is examined with the Shapiro-Wilk test (Akbulut, 2011). In this study, the Shapiro-Wilk normality test results regarding the

scores obtained by the experimental and control groups from the PFQ, ERQ, DASS, and APQ are presented in Table 4.

Table 4. Shapiro-Wilk normality test for the scores

Scale	*Subscale*	*Measurement*	*Group*	*W*	*df*	*p*
PFQ	Values	Pretest	Experimental Group	.927	29	.046
			Control Group	.800	27	.000
		Posttest	Experimental Group	.895	29	.007
			Control Group	.805	27	.000
		Follow-up	Experimental Group	.920	29	.030
			Control Group	.970	27	.591
	Mindfulness	Pretest	Experimental Group	.946	29	.141
			Control Group	.936	27	.098
		Posttest	Experimental Group	.959	29	.309
			Control Group	.966	27	.491
		Follow-up	Experimental Group	.902	29	.011
			Control Group	.980	27	.866
	Acceptance	Pretest	Experimental Group	.961	29	.350
			Control Group	.962	27	.420
		Posttest	Experimental Group	.976	29	.727
			Control Group	.975	27	.725
		Follow-up	Experimental Group	.969	29	.534
			Control Group	.970	27	.593
	Self-as-context	Pretest	Experimental Group	.967	29	.483
			Control Group	.965	27	.472
		Posttest	Experimental Group	.898	29	.009
			Control Group	.971	27	.625
		Follow-up	Experimental Group	.951	29	.197
			Control Group	.952	27	.243
	Defusion	Pretest	Experimental Group	.940	29	.098
			Control Group	.972	27	.646
		Posttest	Experimental Group	.963	29	.383
			Control Group	.981	27	.893
		Follow-up	Experimental Group	.973	29	.630
			Control Group	.907	27	.019
	Total	Pretest	Experimental Group	.981	29	.863
			Control Group	.963	27	.435
		Posttest	Experimental Group	.980	29	.828
			Control Group	.968	27	.543
		Follow-up	Experimental Group	.965	29	.438
			Control Group	.979	27	.830
ERQ	Reappraisal	Pretest	Experimental Group	.965	29	.438
			Control Group	.979	27	.830
		Posttest	Experimental Group	.960	29	.333
			Control Group	.968	27	.555
		Follow-up	Experimental Group	.974	29	.671
			Control Group	.969	27	.586
	Suppression	Pretest	Experimental Group	.945	29	.135
			Control Group	.962	27	.416
		Posttest	Experimental Group	.900	29	.010
			Control Group	.939	27	.116
		Follow-up	Experimental Group	.958	29	.297

Table 4. (continue)

DASS	Depression	Pretest	Experimental Group	.856	29	.001
			Control Group	.826	27	.000
		Posttest	Experimental Group	.818	29	.000
			Control Group	.906	27	.019
		Follow-up	Experimental Group	.876	29	.003
			Control Group	.847	27	.001
	Anxiety	Pretest	Experimental Group	.806	29	.000
			Control Group	.817	27	.000
		Posttest	Experimental Group	.806	29	.000
			Control Group	.817	27	.000
		Follow-up	Experimental Group	.740	29	.000
			Control Group	.842	27	.001
	Stress	Pretest	Experimental Group	.939	29	.092
			Control Group	.891	27	.009
		Posttest	Experimental Group	.918	29	.027
			Control Group	.951	27	.224
		Follow-up	Experimental Group	.933	29	.067
			Control Group	.898	27	.012
APQ	Positive Parenting	Pretest	Experimental Group	.855	29	.001
			Control Group	.889	27	.007
		Posttest	Experimental Group	.863	29	.001
			Control Group	.913	27	.027
		Follow-up	Experimental Group	.884	29	.004
			Control Group	.952	27	.235
	Childcare	Pretest	Experimental Group	.966	29	.458
			Control Group	.916	27	.031
		Posttest	Experimental Group	.955	29	.241
			Control Group	.963	27	.427
		Follow-up	Experimental Group	.951	29	.199
			Control Group	.956	27	.301

As seen in Table 4 above, in the comparison between groups according to the Shapiro-Wilks test results;

- PFQ total score, Acceptance subscale, pretest and posttest of the Defusion subscale, pretest and posttest of the Mindfulness subscale, pretest and follow-up score of the Self-as-context subscale, parametric tests are used because they provide the assumption of normality. However, the Values subscale and posttest measurement of Self-as-context, do not provide the assumption of normality. It was decided to use nonparametric tests for the follow-up measurement of Defusion and Mindfulness.
- In the ERQ, the parametric test was used to test the Reappraisal subscale. For the Suppression subscale, the parametric test was used to test for pretest and follow-up, and the nonparametric test was used to test for posttest.

- Depression, Anxiety and Stress subscale of the DASS did not meet the assumption of normality in three different measurements. It was decided to use nonparametric tests.
- It was decided to use parametric tests for the Childcare subscale of the APQ, as it provided the assumption of normality in the posttest and follow-up measurement. However, it was decided to nonparametric tests for the pretest measurement of the Childcare subscale pretest and the Positive Parenting subscale, which did not provide the assumption of normality.

As seen in Table 4 above, in the comparison of subjects according to the Shapiro-Wilks test results;

- In the PFQ, Total score, Acceptance, and Defusion subscales are by the normal distribution (p>0.05). Since the Values, Mindfulness, and Self-as-context subscales of the PFQ were found to be p<.05 for at least one of the three different measurements of the experimental group, the assumption of normality was not met in these scales. So, the parametric test was used for the Total score, Acceptance, and Defusion subscales, and nonparametric analysis was applied for the Values, Mindfulness, and Self-as-context subscales.
- When the experimental group was analyzed within itself, it was decided to use parametric tests for the Reappraisal subscale of the ERQ, since the normality assumption was met in three different measurements. However, it was decided to use nonparametric tests for the Suppression subscale which did not meet the normality assumption.
- Depression, Anxiety and Stress subscale of the DASS did not meet the assumption of normality in three different measurements. It was decided to use nonparametric tests.
- In the APQ, it was decided to use parametric tests for the Positive Parenting subscale, since the normality assumption was met in three different measurements. However, it was decided to use nonparametric tests for the Childcare subscale which did not meet the normality assumption.

Before the analysis, outliers in the data set were evaluated. The scores obtained from the applied scales and the skewness and kurtosis coefficients of the participants in the experimental and control groups are presented in Table 5 and Table 6, respectively.

Table 5. Skewness and kurtosis values of the scales of the experimental group

Measurement	*Subscale*	*n*	*Min.*	*Max.*	*Mean*	*sd*	*Skewness*	*Kurtosis*
Pretest	Values	29	37	69	58.21	7.821	-.943	.817
	Acceptance	29	7	30	17.24	6.098	.428	-.179
	Defusion	29	8	19	12.55	2.599	.664	.729
	Self-as-context	29	7	20	13.59	3.006	.243	.106
	Mindfulness	29	18	43	33.45	6.423	-.754	.118
	Total	29	99	168	135.03	14.379	.072	.756
Posttest	Values	29	44	69	60.79	7.674	-.791	-.362
	Acceptance	29	7	35	19.86	7.105	.339	-.122
	Defusion	29	5	21	15.17	3.809	-.584	.290
	Self-as-context	29	5	21	16.17	4.293	-.950	.559
	Mindfulness	29	14	45	33.55	7.239	-.507	.359
	Total	29	107	187	145.55	19.229	.164	-.053
Follow-up	Values	29	37	70	59.69	7.834	-.936	1.342
	Acceptance	29	8	33	19.76	6.081	.258	.106
	Defusion	29	10	20	14.97	2.639	-.023	-.535
	Self-as-context	29	6	21	14.93	3.863	-.367	-.572
	Mindfulness	29	17	44	35.31	6.130	-1.223	1.937
	Total	29	113	173	144.66	16.753	-.210	-.842
Pretest	Reappraisal	29	11	36	24.24	6.495	-.385	-.314
	Supression	29	4	24	11.21	5.157	.537	-.266
Posttest	Reappraisal	29	11	36	23.83	6.777	-.300	-.276
	Supression	29	4	24	10.03	5.679	.767	-.298
Follow-up	Reappraisal	29	14	36	25.72	5.561	-.251	-.176
	Supression	29	4	19	11.00	4.359	.208	-.783
Pretest	Depression	29	0	21	7.55	7.303	.613	-1.153
	Anxiety	29	0	16	3.55	3.572	1.982	4.882
	Stress	29	0	20	8.97	6.248	.164	-1.245
Posttest	Depression	29	0	13	3.14	3.461	1.507	2.119
	Anxiety	29	0	9	2.03	2.457	1.308	1.013
	Stress	29	0	19	5.93	4.877	.609	.339
Follow-up	Depression	29	0	15	4.55	4.610	.755	-.425
	Anxiety	29	0	9	2.24	3.008	1.248	.074
	Stress	29	0	17	6.66	5.052	.465	-.718
Pretest	Positive Parenting	29	11	30	25.34	3.976	-1.761	4.947
	Childcare	29	27	50	40.07	5.593	-.427	-.457
Posttest	Positive Parenting	29	13	30	25.59	3.469	-1.598	5.072
	Childcare	29	24	50	40.45	5.980	-.741	.495
Follow-up	Positive Parenting	29	17	30	26.31	3.616	-1.034	.580
	Childcare	29	26	50	41.17	6.487	-.423	-.543

Table 6. Skewness and kurtosis values of the scales of the control group

group

Measurement	*Subscale*	*n*	*Min.*	*Max.*	*Mean*	*sd*	*Skewness*	*Kurtosis*
Pretest	Values	27	14	70	56.33	10.810	-2.258	8.505
	Acceptance	27	5	33	16.11	7.433	.476	-.290
	Defusion	27	6	21	13.37	3.753	.111	.025
	Self-as-context	27	6	21	14.19	3.843	-.363	-.171
	Mindfulness	27	13	42	31.30	6.402	-.980	1.310
	Total	27	102	160	131.30	16.767	.074	-1.069
Posttest	Values	27	24	70	57.07	8.530	-2.097	8.148
	Acceptance	27	5	29	16.00	6.006	.245	-.186
	Defusion	27	6	21	13.07	3.362	.193	.305
	Self-as-context	27	8	21	13.89	3.250	-.023	-.324
	Mindfulness	27	16	42	32.04	6.111	-.456	.329
	Total	27	103	159	132.07	14.866	-.241	-.858
Follow-up	Values	27	42	70	57.59	7.318	-.079	-.774
	Acceptance	27	8	30	17.44	5.480	.190	.074
	Defusion	27	6	21	13.63	3.248	-.499	1.466
	Self-as-context	27	3	20	13.19	3.952	-.564	.772
	Mindfulness	27	17	41	30.22	5.700	-.299	-.304
	Total	27	98	164	132.07	17.679	.098	-.610
Pretest	Reappraisal	27	11	36	24.41	7.266	-.120	-.897
	Supression	27	4	24	12.26	5.201	.446	-.459
Posttest	Reappraisal	27	12	36	24.22	5.700	-.015	.364
	Supression	27	4	21	11.44	5.330	.297	-1.083
Follow-up	Reappraisal	27	11	36	24.56	5.535	-.470	.305
	Supression	27	4	24	12.52	5.258	.251	-.669
Pretest	Depression	27	0	17	5.96	6.003	.885	-.737
	Anxiety	27	0	20	5.70	5.202	1.402	1.983
	Stress	27	0	21	8.22	6.925	.701	-.737
Posttest	Depression	27	0	18	5.96	5.251	.757	-.149
	Anxiety	27	0	19	4.96	5.403	1.420	1.256
	Stress	27	0	21	7.70	5.689	.403	-.342
Follow-up	Depression	27	0	19	4.74	5.193	1.115	.748
	Anxiety	27	0	18	5.00	5.477	1.012	-.085
	Stress	27	0	20	7.48	6.435	.380	-1.256
Pretest	Positive Parenting	27	19	30	26.44	3.130	-1.000	.183
	Childcare	27	33	50	42.59	4.917	-.607	-.567
Posttest	Positive Parenting	27	20	30	26.07	3.088	-.405	-1.114
	Childcare	27	31	50	41.33	5.371	-.278	-.855
Follow-up	Positive Parenting	27	21	30	25.70	2.431	.166	-.850
	Childcare	27	31	50	40.78	4.627	-.317	-.369

Skewness and kurtosis coefficients are considered perfect for many psychometric measurements when they are between -1 and +1, while values between -2 and +2 are also acceptable in many cases (George & Mallery, 2012). Many skewness and kurtosis coefficients are found for both experimental and control groups, values are close to symmetry, which indicates that the score distributions are balanced. However, it was

observed that some values had high kurtosis values. Therefore, a boxplot was created for the experimental and control groups and outliers were evaluated to identify potential outliers and extreme values in the data set (see Figures 3, 4, 5, 6, 7, 8, 9, 10). Values are determined as points outside the box in the boxplot. These values are points that lie outside the general distribution of the data set. The extreme values determined in the analysis should be examined according to the characteristics and distribution of the data set.

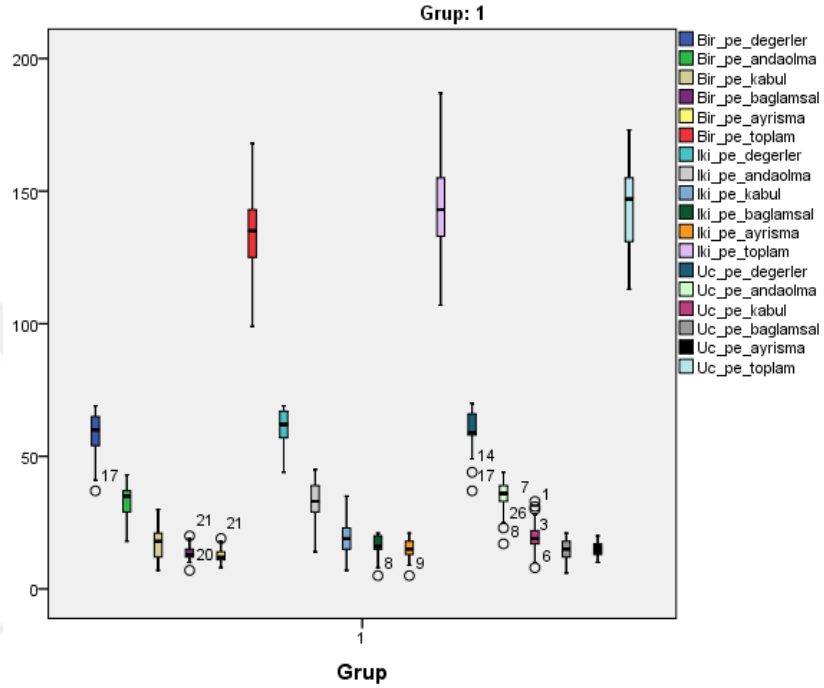


Figure 3. Boxplot for PFQ measurements of experimental group

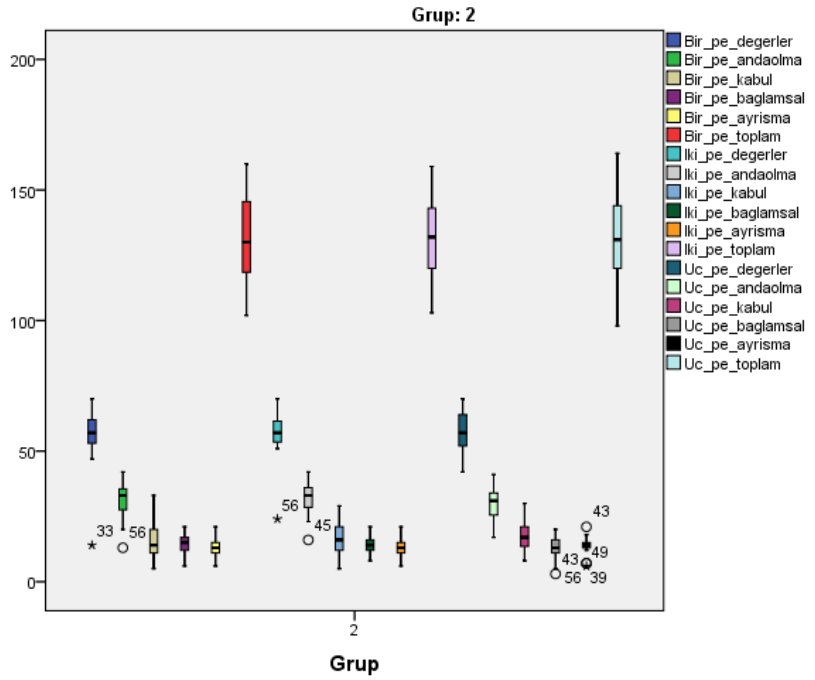


Figure 4. Boxplot for PFQ measurements of control group

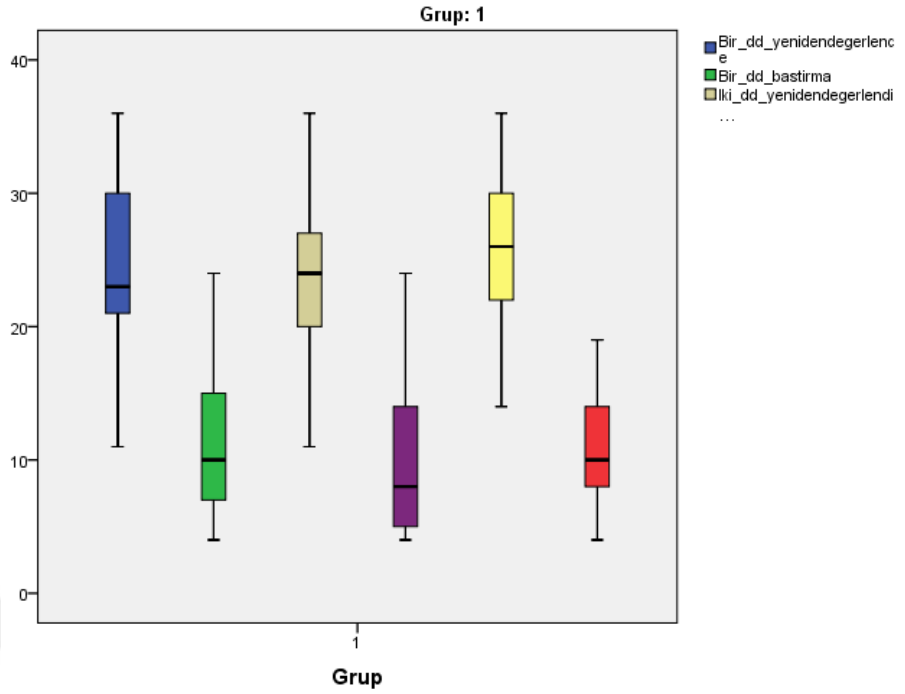


Figure 5. Boxplot for ERQ measurements of experimental group

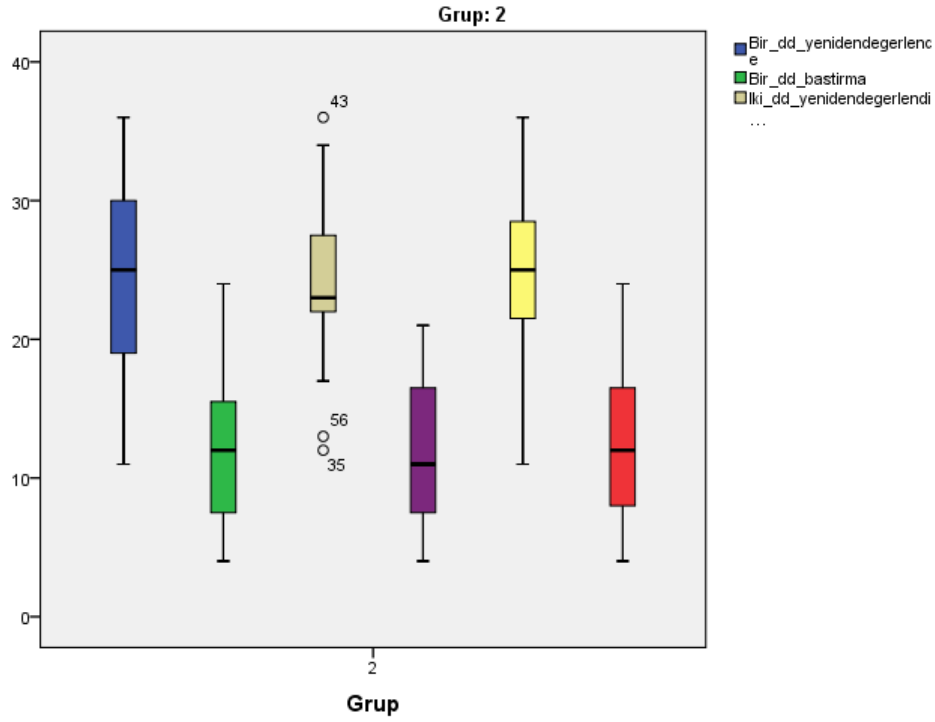


Figure 6. Boxplot for ERQ measurements of control group

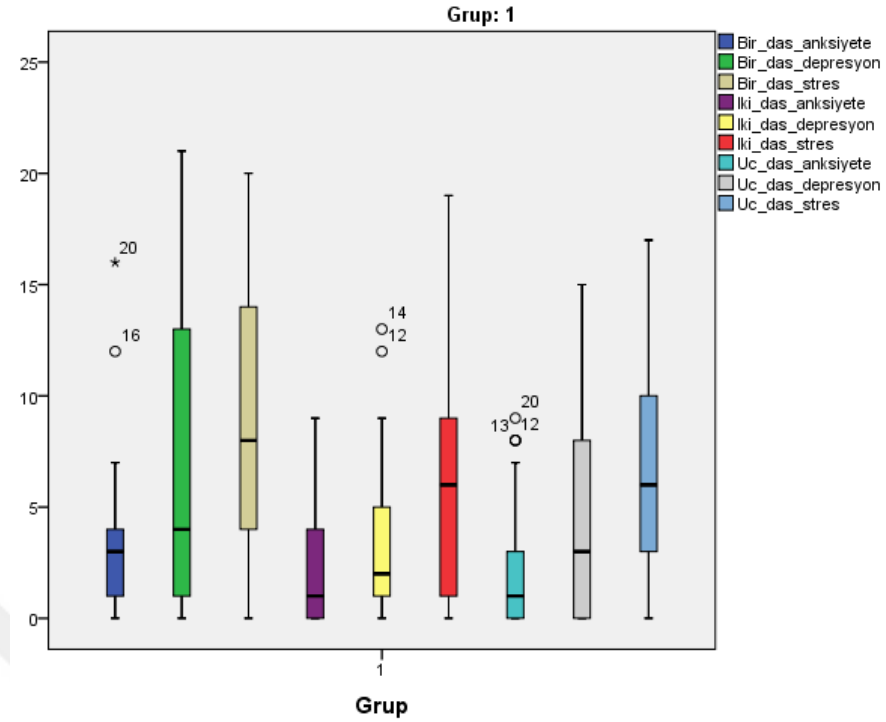


Figure 7. Boxplot for DASS measurements of experimental group

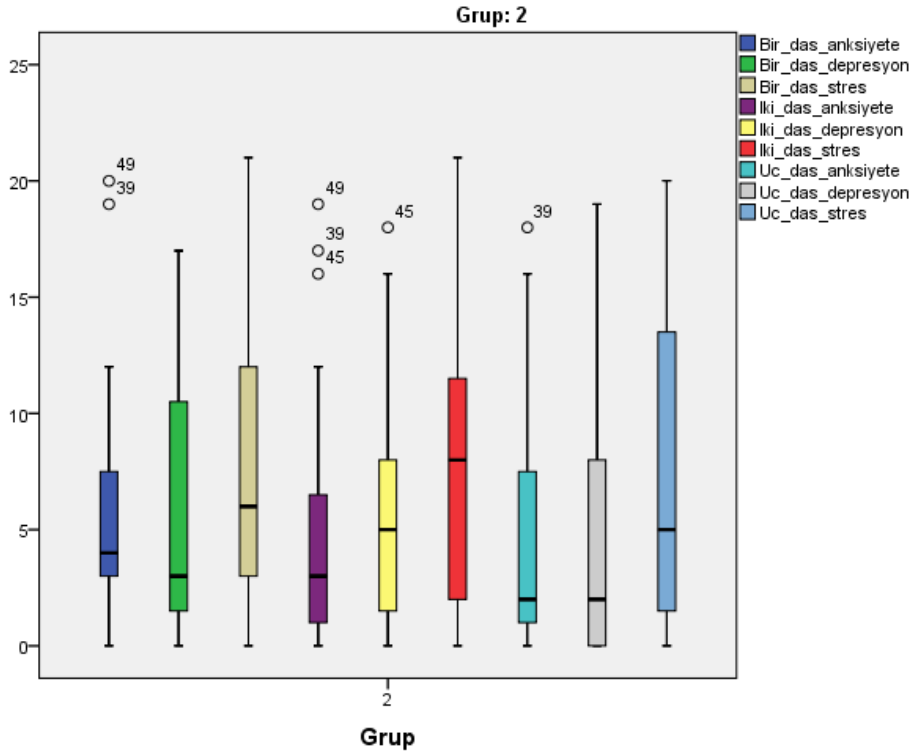


Figure 8. Boxplot for DASS measurements of control group

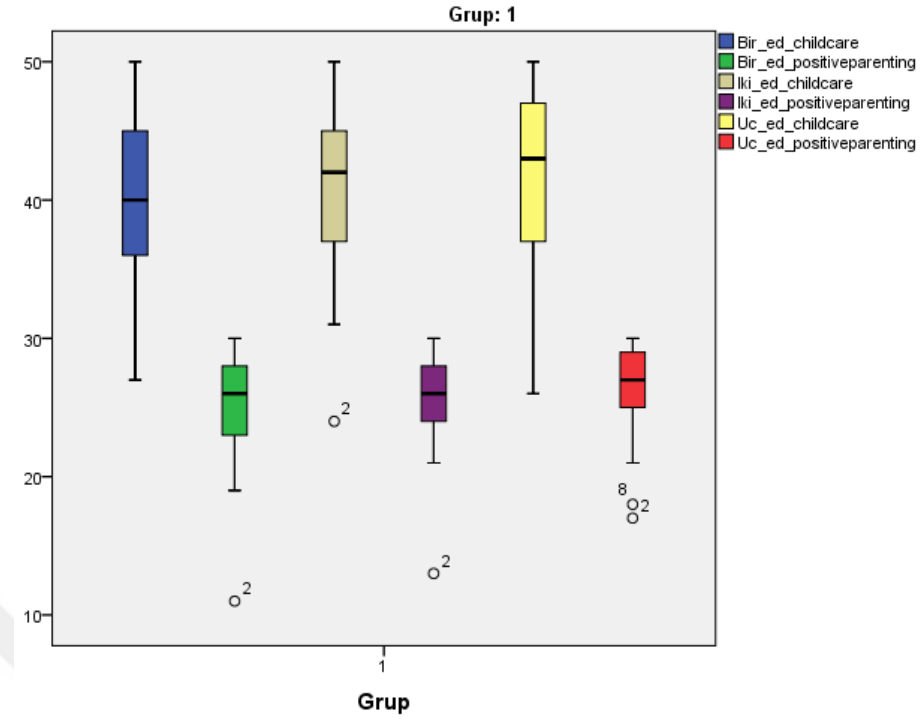


Figure 9. Boxplot for APQ measurements of experimental group

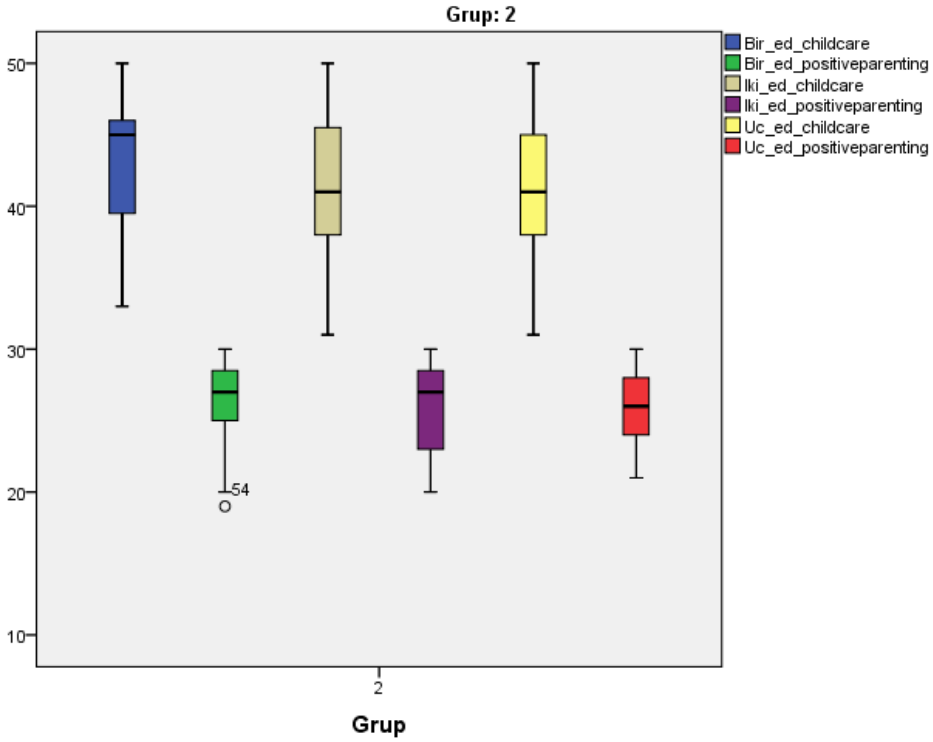


Figure 10. Boxplot for APQ measurements of control group

As seen in the figures above, some outliers were detected in the scales at the different time measurements of the participants in the experimental and control groups. At this point, several methods can be applied to support the normal distribution of the data. The most common of these is removing or transforming outliers. In psychology and similar disciplines, an in-depth examination of inter-individual differences is essential. For this reason, observations identified as outliers were retained in the analysis because they may contain important information. Preserving these observations rather than removing them from the data set prevents the loss of data that more effectively reflects individual differences and expands the scope of the findings. It is intended to obtain reliable results across a wider range of data, considering the potential impact of outliers. Therefore, it was decided to protect the values determined as contradictory.

Applying parametric tests for data that meet the assumption of normality and applying nonparametric tests for data that do not meet the assumption of normality increased the reliability and breadth of the research and allowed the effects of therapy to be evaluated more realistically.

At this point, parametric tests were applied for normally distributed data. For normally distributed data, the Independent Samples t-Test was used to test whether there was a statistically significant difference between the experimental and control groups. Repeated Measures ANOVA was used to test the experimental group in different measurements. Additionally, nonparametric tests were applied for data that did not comply with normal distribution. For data that is not normally distributed, the Mann-Whitney U test was used to test whether there was a statistically significant difference between the experimental and control groups. Friedman test was used to test the between the experimental group in different measurements.

If the data is normally distributed data, the Independent Samples t-Test, a parametric test, was used when comparing the experimental and control groups. The average test scores of the experimental group are compared with the average test scores of the control group. When performing this test, the data must be normally distributed, the variances of the groups must be equal (homogeneity of variance) and there must be independent groups. Equality of variances is measured by Levene's test. Analyzes were carried out by paying attention to these issues.

The Repeated Measures ANOVA is a parametric test, the test used when the data is normally distributed. It is used to analyze whether there is a significant difference between the averages of the data obtained because of more than two measurements on the same sample. Therefore, this type of analysis is called repeated measures because there is dependency. For the analysis to give accurate results, the assumption of sphericity, which states that the average of the results of the measurements and the variances of the differences of each of the measurements from the average, must be met. Whether this assumption is met or not is checked by "Mauchly's Test of Sphericity". If sphericity is not achieved, the results are interpreted by making corrections according to the epsilon value. In our study, analyses, and procedures were carried out by paying attention to these issues.

Friedman Test was used to test whether there was a statistically significant difference by comparing the measurements experimental group at three different times within the group. The nonparametric equivalent of Repeated Measures ANOVA is the Friedman Test. The Friedman test is a non-parametric statistical test used to analyze the results of repeated measurements on dependent or matched groups. This test is especially useful when the data are not normally distributed. The test ranks the measurements obtained under each condition and evaluates the differences between these ranks to determine whether there is a significant difference between the groups. Its use of a rank-based approach makes it independent of the form of the data distribution, making it popular in a wide range of application areas and fields of psychology. In our study, pretest, posttest, and follow-up tests were applied to the participants in the experimental group and these test results were compared with Friedman analysis. The results obtained at each time point provided important information about the short and long-term effects of the treatment. The use of the Friedman test enabled objective evaluation of the continuity and change of the effects of therapy over time, thus obtaining concrete data on the effectiveness of treatment methods. In cases where a significant difference was detected in the Friedman test, the Wilcoxon Signed-Ranks Test was applied to determine the source of the difference.

In nonparametric analyses, the Mann-Whitney U test was used to test whether there was a statistically significant difference in comparisons between groups. This test is suitable for evaluating median differences between two independent groups and is a preferred nonparametric test, especially when data distributions are not normal. This test allows us to

determine whether there is a statistically significant difference between two groups by comparing group medians, under the assumption that the distribution patterns are similar.

In line with all this information, explanatory information about the parametric and nonparametric analyses applied to the scales and subscales within the scope of the current study can be seen in Figure 11.

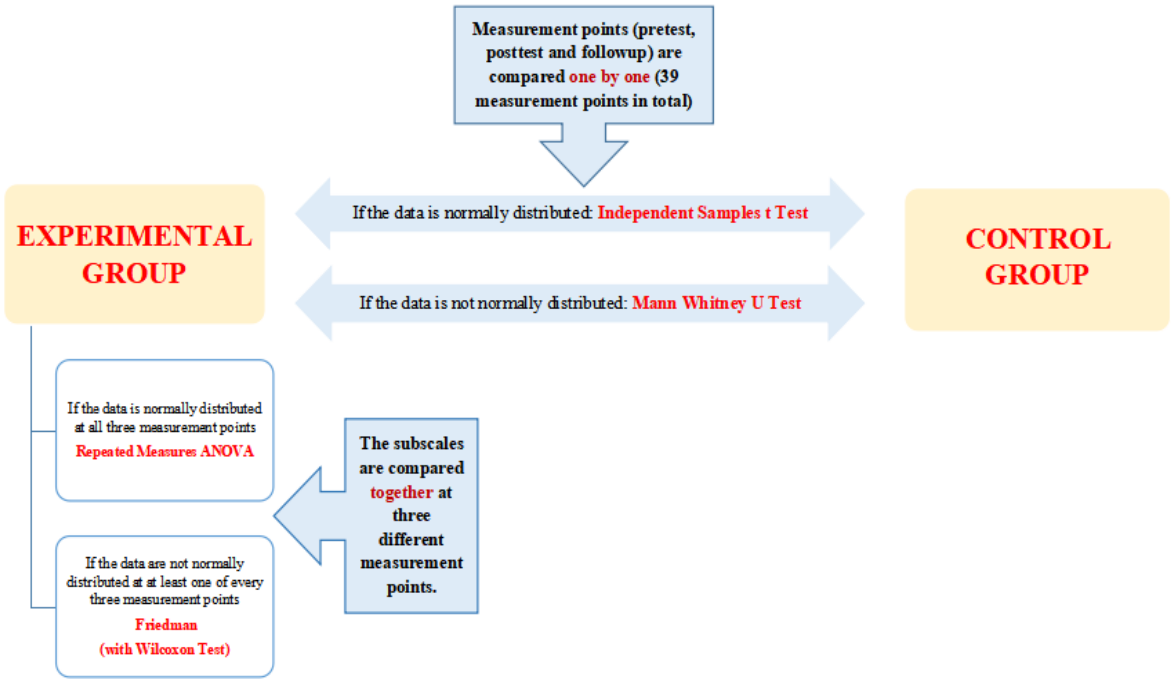


Figure 11. Summary of the analysis of the study

3. RESULTS

This section includes a descriptive analysis of the demographic data obtained in the research, descriptive statistics of the scales used, reliability analysis of the scales used, and the results of the analyses carried out to test the hypotheses.

3.1. Findings From Descriptive Analysis

3.1.1. Demographic Findings

In this section, the mean and standard deviation values of the variables are discussed and the differences between the variables among the participants are examined. Of the 56 people participating in the research, 54 (96.4%) are women and two (3.6%) are men. The ages of the participants ranged between 26-52 ($\overline{X}$ = 37.43 ± 5.15). In the sample consisting of divorced parents, the number of children varies between 1-4 ($\overline{X}$ = 1.71 ± 0.76). 29 of the participants were in the experimental group and 27 in the control group.

When we look at the sample in terms of educational status, 3.6% of the sample is a primary school graduate, 28.6% is high school graduate, 12.5% is an associate degree graduate, 46.4% is undergraduate graduate, 5.4% have master's degree, and 3.6% have a doctorate. When the sample is examined in terms of occupation status, 9 people (16.1%) in the sample are housewives, 19 people (33.9%) are teachers, 8 people (14.3%) are public personnel, and 13 people (23.2%) are private sector employees, 2 people (3.6%) were in the retired category and 5 people (8.9%) were in the other category. Data regarding the education and profession of the sample are included in Table 7.

Table 7. Distribution of the sample in terms of education and occupational status

Variable		*n*	*%*
Educational status	Primary school graduate	2	3.6
	High school graduate	16	28.6
	Associate degree graduate	7	12.5
	Bachelor's degree	26	46.4
	Master's degree	3	5.4
	PhD graduate	2	3.6
Occupation	Housewife	9	16.1
	Teacher	19	33.9
	Civil servant	8	14.3
	Private sector employee	13	23.2
	Retired	2	3.6
	Other	5	8.9
	Total	56	100

Considering the duration of marriage of the sample; one (1.8%) had been married for less than a year, eight (14.3%) had been married for 1-5 years, 17 people (30.4%) had been married for 6-10 years, 16 people (% 28.6) have been married for 11-15 years, 11 people (19.6%) have been married for 16-20 years, two (3.6%) have been married for 21-25 years and one (1.8%) has been married for more than 26 years. The period after divorce is at most five years, by the inclusion criteria, and the average is 1.96 (SD = 1.39) years. When the participants were asked who decided on the divorce, 30 people (53.6%) said it was their own decision, 13 people (23.2%) said it was a mutual decision, seven (12.5%) said the other spouse made the divorce decision, and six people (10.7%) was stated as other. After the divorce, the participants were asked about their receiving and giving alimony. Regarding alimony, it was determined that 54 people (96.4%) did not give any alimony, one (1.8%) gave precautionary alimony and poverty alimony, while one person (1.8%) gave precautionary alimony, poverty alimony and participation alimony. In case of receiving alimony, it was determined that nine (16.1%) do not receive any alimony, 29 people (51.8%) receive only participation alimony, two people (3.6%) receive only precautionary alimony, one (1.8%) receive only poverty alimony, eight (14.3%) people receive participation and poverty alimony, five (8.9%) receive precautionary and participation alimony, and two people (3.6%) receive all types of alimony. Information about custody of the child/children and who they stayed with after the divorce was also obtained. At this point, 45 participants (80.4%) stated that the mother has custody of their children, three participants (5.4%) stated that the father has custody of the children, and eight participants (14.3%) stated that they

have joint custody of the children. Significantly, it was learned that while the child/children of 51 participants lived with the mother (91.1%), the children of two participants (3.6%) lived with the father, and the children of three participants (5.4%) lived with other people. Information about the duration of marriage of the participants, the person who made the decision, alimony status, custody of the children, and the people they live with are presented in Table 8.

Table 8. Distribution of the sample in terms of variables related to divorce

Variable		*n*	*%*
Duration of marriage	Less than 1 year	1	1.8
	1-5 years	8	14.3
	6-10 years	17	30.4
	11-15 years	16	28.6
	16 -20 years	11	19.6
	21-25 years	2	3.6
	26 years and above	1	1.8
Decision Maker	Me	30	53.6
	Other	7	12.5
	Mutual	13	23.2
	Other	6	10.7
Alimony Receipt Status	Temporary alimony	9	16.1
	Child maintenance	44	78.58
	Poverty alimony	11	19.64
	None	9	16.1
Alimony Giving Status	Temporary alimony	1	1.8
	Child maintenance	2	3.6
	Poverty alimony	2	3.6
	None	54	96.4
Child Custody	Belongs to the mother	45	80.4
	Belongs to the father	3	5.4
	Joint custody	8	14.3
Child Residence	With mother	51	91.1
	With father	2	3.6
	Other	3	5.4
	Total	102	100.0

Participants were asked about the impact of divorce on their lives and work situations, and from whom they received support in the post-divorce period. It was stated by 38 people (67.8%) that the house they lived in, by 22 people (39.3%) that their relationships with their children, by 20 people (35.7%) that their work, by 35 people (62.5%) that their order in the house, by 16 people (28.6%) that their relationships with their friends, and by 30 people (53.6%) that their relationships with their friends were affected. Only one

participant reported that no area of his life was affected. When the social support received by the participants after divorce was evaluated; it was stated by 38 people (67.9%) that they received brother/sister support, 37 people (66.1%) mother's support, 32 people (57.1%) that they receive friend support, by 30 people (53.6%) that they receive father's support, by 16 people (28.6%) that they received relative support and by 12 people (21.4%) that they received child support. Six of the participants (10.7%) stated that they did not receive support from anyone after the divorce. When the change in the employment status of the participants before and after the divorce was examined, it was seen that 19 people (33.9%) were not working and still are not working, nine (16.1%) were not working but are now working, 24 people (42.9%) were working and still working and four (7.1%) were working but now no longer working. Information on relevant variables is presented in Table 9.

Table 9. Distribution of the sample in terms of the post-divorce process

Variable		*n*	*%*
Impact on life	Living home	38	67.8
	Relationship with children	22	39.3
	Work	20	35.7
	Order in the house	35	62.5
	Relationship with friends	16	28.6
	Health	30	53.6
	None	1	1.8
Social support	Mother	37	66.1
	Father	30	53.6
	Children	12	21.4
	Brother/Sister	38	67.9
	Relatives	16	28.6
	Friends	32	57.1
	None	6	10.7
Work situation	wasn't working, and still isn't working	19	33.9
	wasn't working but now is working	9	16.1
	was working and still working	24	42.9
	was working but is not working anymore	4	7.1

Additionally, eight people (14.3%) from the sample group reported receiving psychiatric support and using medication. Participants were asked whether they received psychological support or psychotherapy for the problems they experienced during and after the divorce process. While 36 people (64.3%) stated that they did not receive any support, 20 people (35.7%) stated that they received support. When we look at the details of psychotherapy, it can be seen that a few or one-time counseling support is generally received, especially during the process of informing the child about the divorce, one person provides

support for about three months before the official divorce, two people provide support for about six months immediately after the divorce, two people provide support for about three months, and one person provides support for about a year. It was observed that one person received support as needed for five years. Participants were also asked whether they smoked or consumed alcohol. 25% of the participants stated that they used cigarettes and 7.1% used alcohol.

3.1.2. Descriptive Statistics of Scales

In addition to the personal information form, the Psychological Flexibility Scale (PFQ), Emotion Regulation Questionnaire (ERQ), Depression Anxiety Stress Scale (DASS), and Alabama Parenting Questionnaire (APQ) were applied to the participants of the study. 5 subscales of FPQ, 2 subscales of ERQ, 3 subscales of DASS, and 2 subscales of APQ were applied within the scope of this study. Descriptive statistics results regarding the maximum and smallest values, mean and standard deviation values obtained from the subscales are given in Table 5.

The scores obtained from the PFQ subscales of the participants were compared in the pretest, posttest, and follow-up periods. The PFQ total pretest score average ($\bar{x}$ = 135.03) of the experimental group is critically different from the posttest score average ($\bar{x}$ = 145.55) and follow-up test score average ($\bar{x}$ = 144.66). Considering the test score averages, it can be said that the intervention applied in the experimental group increased psychological flexibility. The experimental group generally shows an increase in some subscales (Values, Acceptance, Defusion, Self-as-context, Mindfulness) and total scores in both the posttest and follow-up tests compared to the pretest period. On the other hand, the PFQ total pretest score average ($\bar{x}$ = 131.30) of the control group was determined as the posttest score average ($\bar{x}$ = 132.07) and follow-up test score average ($\bar{x}$ = 132.07). Although there is an increase in the psychological flexibility scores of the control group, there is no obvious change. Further analyses were conducted to determine whether the increase in the experimental and control groups created a significant difference. Information about the scores obtained from the PFQ by the participants in the experimental and control groups is presented in Table 10.

Table 10. Values of PFQ subscales for the groups

			Pretest		*Posttest*		*Follow-up*	
Scale	*Subscale*	*n*	*Mean*	*sd*	*Mean*	*sd*	*Mean*	*sd*
Experi	Values	29	58.21	7.821	60.79	7.674	59.69	7.834
mental	Acceptance	29	17.24	6.098	19.86	7.105	19.76	6.081
Group	Defusion	29	12.55	2.599	15.17	3.809	14.97	2.639
	Self-as-context	29	13.59	3.006	16.17	4.293	14.93	3.863
	Mindfulness	29	33.45	6.423	33.55	7.239	35.31	6.130
	Total	29	135.3	14.379	145.55	19.229	144.66	16.753
Control	Values	27	56.33	10.810	57.07	8.530	57.59	7.318
Group	Acceptance	27	16.11	7.433	16.00	6.006	17.44	5.480
	Defusion	27	13.37	3.753	13.07	3.362	13.63	3.248
	Self-as-context	27	14.19	3.843	13.89	3.250	13.19	3.952
	Mindfulness	27	31.30	6.402	32.04	6.111	30.22	5.700
	Total	27	131.0	16.767	132.07	14.866	132.07	17.679

In Table 11, the scores obtained from the ERQ subscales of the participants in the experimental and control groups are compared in the pretest, posttest, and follow-up periods. It is seen that the average Reappraisal pretest score of the experimental group is $\bar{x}$ = 24.24, the average posttest score is $\bar{x}$ = 23.83 and the average follow-up test score is $\bar{x}$ = 25.72. It is seen that the average Suppression pretest score of the experimental group is $\bar{x}$ = 11.21, the average posttest score is $\bar{x}$ = 10.03 and the average follow-up test score is $\bar{x}$ = 11.00. On the other hand, it was determined that the average Reappraisal pretest score of the control group is $\bar{x}$ = 24.41, the average posttest score is $\bar{x}$ = 24.22, and the average follow-up test score is $\bar{x}$ = 24.56. It was determined that the mean Suppression pretest score of the control group is $\bar{x}$ = 12.26, the mean posttest score is $\bar{x}$ = 11.44, and the mean follow-up test score is $\bar{x}$ = 12.52. In summary, the experimental group showed an increase in Reappraisal scores on the follow-up test, while there is a decrease in Suppression scores. In the control group, while no significant change is observed in Reappraisal scores, a decrease in Suppression scores is observed in the posttest and an increase again in the follow-up test.

Table 11. Values of ERQ subscales for the groups

			Pretest		*Posttest*		*Follow-up*	
Scale	*Subscale*	*n*	*Mean*	*sd*	*Mean*	*sd*	*Mean*	*sd*
Experimental	Reappraisal	29	24.24	6.495	23.83	6.777	25.72	5.561
Group	Supression	29	11.21	5.157	10.03	5.679	11.00	4.359
Control Group	Reappraisal	27	24.41	7.266	24.22	5.700	24.56	5.535
	Supression	27	12.26	5.201	11.44	5.330	12.52	5.258

Information about the scores obtained by the participants from the DASS is included in Table 12. It compares the scores obtained from the subscales of the participants in the experimental and control groups in the pretest, posttest, and follow-up periods. The Depression subscale pretest score average of the experimental group is $\bar{x}$ = 7.55, the posttest average score is $\bar{x}$ = 3.14, and the follow-up test score average is $\bar{x}$ = 4.55; Anxiety subscale pretest score average is $\bar{x}$ = 3.55, posttest average score is $\bar{x}$ = 2.03 and follow-up test score average is $\bar{x}$ = 2.24, and Stress subscale pretest score average is $\bar{x}$ = 8.97, posttest average score is $\bar{x}$ = 5.93. and the follow-up test score average is determined as $\bar{x}$ = 6.66. On the other hand, the Depression subscale pretest score average of the control group is $\bar{x}$ = 5.96, the posttest average score is $\bar{x}$ = 5.96, and the follow-up test score average is $\bar{x}$ = 4.74; Anxiety subscale pretest score average is $\bar{x}$ = 5.70, posttest average score is $\bar{x}$ = 4.96, follow-up test score average is $\bar{x}$ = 5.00, and Stress subscale pretest score average is $\bar{x}$ = 8.22, posttest average is $\bar{x}$ = 7.70. and the follow-up test score average is determined as $\bar{x}$ = 7.48. In summary, depression, anxiety, and stress scores in the experimental group showed a decrease in the posttest and follow-up tests. In the control group, while a decrease is observed in depression scores in the follow-up test, no significant change is observed in anxiety and stress scores.

Table 12. Values of DASS subscales for the groups

			Pretest		*Posttest*		*Follow-up*	
Scale	*Subscale*	*n*	*Mean*	*sd*	*Mean*	*sd*	*Mean*	*sd*
Experimental Group	Depression	29	7.55	7.303	3.14	3.461	4.55	4.610
	Anxiety	29	3.55	3.572	2.03	2.457	2.24	3.008
	Stress	29	8.97	6.248	5.93	4.877	6.66	5.052
Control Group	Depression	27	5.96	6.003	5.96	5.251	4.74	5.193
	Anxiety	27	5.70	5.202	4.96	5.403	5.00	5.477
	Stress	27	8.22	6.925	7.70	5.689	7.48	6.435

Finally, the scores obtained from the APQ in the experimental and control groups were compared in the pretest, posttest, and follow-up periods. The Positive Parenting pretest mean score of the participants in the experimental group is $\bar{x}$ = 25.34, the posttest mean score is $\bar{x}$ = 25.59, and the follow-up test mean score is $\bar{x}$ = 26.31. The pretest mean score of the participants in the control group was $\bar{x}$ = 26.44, the posttest mean score was $\bar{x}$ = 26.07, and the follow-up test score average was determined as $\bar{x}$=25.70. When the Childcare subscale scores are evaluated, the pretest mean score of the participants in the experimental group is $\bar{x}$ = 40.07, the posttest mean score is $\bar{x}$ = 40.45, and the follow-up test score means is $\bar{x}$ =

41.17, while the pretest mean score of the participants in the control group is $\bar{x}$ = 42.59, and the posttest mean score is determined as $\bar{x}$ = 40.45, and the follow-up test score average is determined as $\bar{x}$ = 40.78. In summary, Positive Parenting and Childcare scores in the experimental group show a slight increase in the posttest and follow-up tests. In the control group, while a slight decrease is observed in Positive Parenting scores in the follow-up test, no significant change is observed in Childcare scores. Information on the scores obtained from the APQ is included in Table 13.

Table 13. Values of APQ subscales for the groups

			Pretest		*Posttest*		*Follow-up*	
Scale	*Subscale*	*n*	*Mean*	*sd*	*Mean*	*sd*	*Mean*	*sd*
Experimental Group	Positive Parenting	29	25.34	3.976	25.59	3.469	26.31	3.616
	Childcare	29	40.07	5.593	40.45	5.980	41.17	6.487
Control Group	Positive Parenting	27	26.44	3.130	26.07	3.088	25.70	2.431
	Childcare	27	42.59	4.917	41.33	5.371	40.78	4.627

3.1.3. Reliability Analysis of the Scales

Reliability analysis of PFQ, ERQ, DASS, and APQ used within the scope of this research was performed. For the validity and reliability of the PFQ, Cronbach's Alpha value was calculated at a 95% confidence level. In the analysis conducted on 56 people, the scale is found to be reliable (28 items; α = .74). The analysis results according to the subscales are α = .80 (5 items) for the Acceptance subscale, α = .58 (3 items) for the Defusion subscale, α = .90 (10 items) for the Values subscale, α = .90 (10 items) for the Mindfulness subscale. It is found α = .61 (3 items) for the Self-as-context subscale.

Within the scope of the research, the validity and reliability of the ERQ were calculated at a 95% confidence level and the scale was found to be reliable. For the Reappraisal subscale, α = .88 (6 items), and for the Suppression subscale, α = .83 (4 items). The validity and reliability of the DASS was calculated on 56 people at a 95% confidence level. In the analysis, the scale was found to be reliable. The analysis results according to subscales were determined as α = .94 (7 items) for the Depression subscale, α = .82 (7 items) for the Anxiety subscale, and α = .92 (7 items) for the Stress subscale. For the study, the validity and reliability of the 2 subscales of the APQ were calculated at a 95% confidence

level and the scale was found to be reliable. In the analysis results according to subscales, it was determined that α = .75 (6 items) for the Positive Parenting subscale and α = .76 (10 items) for the Childcare subscale. When the Cronbach Alpha value obtained from the sample for the scales used in the research is evaluated, it can be said that all scales are valid and reliable measurement tools for the research.

3.2. Findings From Testing the Hypotheses

3.2.1. Findings Related to the Hypothesis about Psychological Flexibility

In this section, the 1st Hypothesis of the research was tested by comparing the PFQ scores regarding the psychological flexibility levels of individuals in the experimental and control groups.

Hypothesis 1:

"H1: The ACT-based intervention will result in a significant difference between the experimental and control groups on psychological flexibility.

H1.1. The ACT-based intervention will result in a significant difference between the experimental and control groups on the Psychological Flexibility total score.

H1.2. The ACT-based intervention will result in a significant difference between the experimental and control groups on Acceptance.

H1.3. The ACT-based intervention will result in a significant difference between the experimental and control groups on Defusion.

H1.4. The ACT-based intervention will result in a significant difference between the experimental and control groups on Mindfulness.

H1.5. The ACT-based intervention will result in a significant difference between the experimental and control groups on Self-as-context.

H1.6. The ACT-based intervention will result in a significant difference between the experimental and control groups on Values.

H1.7. The ACT-based intervention will result in a significant difference within the experimental group on Psychological Flexibility total score between the pretest, posttest, and follow-up tests.

H1.8. The ACT-based intervention will result in a significant difference within the experimental group in Acceptance scores between the pretest, posttest, and follow-up tests.

H1.9. The ACT-based intervention will result in a significant difference within the experimental group on Defusion score between the pretest, posttest, and follow-up test.

H1.10. The ACT-based intervention will result in a significant difference within the experimental group on Mindfulness scores between the pretest, posttest, and follow-up tests.

H1.11. The ACT-based intervention will result in a significant difference within the experimental group on Self-as-context scores between the pretest, posttest, and follow-up tests.

H1.12. The ACT-based intervention will result in a significant difference within the experimental group on Values score between the pretest, posttest, and follow-up test."

Between Group Analysis

Within the scope of the study, psychological flexibility was evaluated with scores obtained from the PFQ. PFQ total score, Acceptance subscale, pretest and posttest of the Defusion subscale, pretest and posttest of the Mindfulness subscale, pretest and follow-up score of the Self-as-context subscale, parametric tests are used because they provide the assumption of normality. However, the Values subscale and posttest measurement of Self-as-context, do not provide the assumption of normality. It was decided to use nonparametric tests for the follow-up measurement of Defusion and Mindfulness.

An Independent Samples t-test was conducted to compare psychological flexibility total scores for three different time measurements across groups. Pretest scores of experimental group (*M*= 135.03, *SD*=14.379) and control group (*M*= 131.30, *SD*= 16.767), posttest scores of experimental group (*M*= 145.55, *SD*=19.229) and control group (M= 132.07, *SD*= 14.866) and follow-up scores of experimental group (*M*= 144.66, *SD*=16.753) and control group (*M*= 132.07, *SD*= 17.679) can be seen in Table 14.

Table 14. Descriptive statistics for PFQ total scores

Measurement		*M*	*SD*
Pretest	Experimental Group	135.03	14.379
	Control Group	131.30	16.767
Posttest	Experimental Group	145.55	19.229
	Control Group	132.07	14.866
Follow-up	Experimental Group	144.66	16.753
	Control Group	132.07	17.679

The assumption of equal variances was tested using Levene's Test. The result indicated that homogeneity of variance was achieved for the pretest (F=1.625, p=.208), posttest (F= 1.259, p=.267), and the follow-up (F=.00, p=.987). So equal variances are assumed for the test. The t-test results showed that before the implementation of the program there was no significant difference in psychological flexibility score between experimental and control group $t(54) = 0.897$, $p = .373$, 95% CI [-4.612, 12.089]. However, after the implementation of the program there is a significant difference in Psychological flexibility scores between the experimental group (M=145.55, SD=19.229) and control group (M=132.07, SD=14.866), [$t(54) = 2.919$, $p = 0.005 < .05$]. The 95% confidence interval of the difference between means ranged from [4.22 to 22.735] and indicated a difference between the means of the sample. There is also a significant difference in follow-up measurement of psychological flexibility between the experimental group (M=144.66, SD=16.753) and control group (M=132.07, SD=17.679), [$t(54) = 2.734$, $p = 0.008 < .05$], 95% CI [3.356, 21.806] (Table 15). Therefore, we can conclude that there is sufficient evidence that the experimental group had statistically significantly higher psychological flexibility at the end of the program and one month later compared to the control group. These results indicate that the ACT-based intervention program has a statistically significant impact on psychological flexibility both after the program and this significant impact continues even one month later.

Table 15. Independent samples t-test for PFQ

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	*Sig.*	*t*	*df*	*Sig (2-tailed)*	*Mean Difference*	*Std. Error Difference*	*Lower*	*Upper*
Pretest	Equal variances assumed	1.625	0.208	0.897	54	0.373	3.738	4.165	-4.612	12.089
	Equal variances not assumed			0.893	51.412	0.376	3.738	4.188	-4.669	12.145
Posttest	Equal variances assumed	1.259	0.267	2.919	54	0.005	13.478	4.618	4.22	22.735
	Equal variances not assumed			2.946	52.284	0.005	13.478	4.575	4.297	22.658
Follow-up	Equal variances assumed	0	0.987	2.734	54	0.008	12.581	4.601	3.356	21.806
	Equal variances not assumed			2.729	53.151	0.009	12.581	4.61	3.335	21.827

An Independent Samples t-Test was conducted to determine whether there was a difference in Acceptance scores between experimental and control groups. Information about the scores of the experimental and control groups on the Acceptance subscale is presented in Table 16.

Table 16. Descriptive statistics for acceptance scores

Measurement		*M*	*SD*
Pretest	Experimental Group	17.24	6.098
	Control Group	16.11	7.433
Posttest	Experimental Group	19.86	7.105
	Control Group	16.00	6.006
Follow-up	Experimental Group	19.76	6.081
	Control Group	17.44	5.480

The assumption of equal variances was tested using Levene's Test. The result indicated that homogeneity of variance was achieved for the pretest (F= 1.662, p=.203), posttest (F=.634, p=.429), and the follow-up (F= .074, p=.786). The results indicate not a significant difference between the pretest score of the experimental group (M=17.24, SD=6.098) and control group (M=16.11, SD=7.433), [$t(54) = 0.624$, p =.535 >.05]. There is

also no significant difference in Acceptance follow-up scores between the experimental group (M=19.76, SD=6.081) and control group (M=17.44, SD=5.480), [$t(54) = 1.492$, $p = .141 > .05$]. There was a significant difference in Acceptance scores at posttest measurement between the experimental group (M=19.86, SD=7.105) and control group (M=16.00, SD=6.006), [$t(54) = 2.188$, $p = .033 > .05$]. The 95% confidence interval of the difference between means ranged from [0.324 to 7.4] and indicated a difference between the means of the sample (Table 17).

Table 17. Independent samples t-test for acceptance

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	*Sig.*	*t*	*df*	*Sig (2-tailed)*	*Mean Difference*	*Std. Error Difference*	*Lower*	*Upper*
Pretest	Equal variances assumed	1.662	0.203	0.624	54	0.535	1.13	1.812	-2.502	4.762
	Equal variances not assumed			0.619	50.413	0.538	1.13	1.825	-2.534	4.794
Posttest	Equal variances assumed	0.634	0.429	2.188	54	0.033	3.862	1.765	0.324	7.4
	Equal variances not assumed			2.202	53.522	0.032	3.862	1.754	0.345	7.38
Follow-up	Equal variances assumed	0.074	0.786	1.492	54	0.141	2.314	1.551	-0.795	5.423
	Equal variances not assumed			1.498	53.947	0.14	2.314	1.545	-0.783	5.412

Descriptive statistics for the Defusion score of groups are provided in Table 18. An Independent Samples t-Test was conducted to determine whether the Defusion score difference is statistically significant between experimental and control groups.

Table 18. Descriptive statistics for defusion scores

Measurement		*M*	*SD*
Pretest	Experimental Group	12.55	2.599
	Control Group	13.37	3.753
Posttest	Experimental Group	15.17	3.809
	Control Group	13.07	3.362

The assumption of equal variances was tested using Levene's Test. The result indicated that homogeneity of variance was achieved for the pretest (F= 2.901, p=.094), and posttest (F=0.88, p=.352). An Independent Samples t-Test results show that before the implementation of the program, there was no statistically significant difference between groups, $t(54) = -0.954$, $p = .344 > .05$. There is a significant difference of Defusion scores at posttest measurement between experimental group (M=15.17, SD=3.809) and control group (M=13.07, SD=3.362), [$t(54) = 2.179$, $p = .034 > .05$] with the confidence interval ranged from 0.168 to 4.029. It means that the intervention program has a statistically significant impact on Defusion with a higher score for the experimental group (Table 19).

Table 19. Independent samples t-test for defusion

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	*Sig.*	*t*	*df*	*Sig (2-tailed)*	*Mean Difference*	*Std. Error Difference*	*Lower*	*Upper*
Pretest	Equal variances assumed	2.901	0.094	-0.954	54	0.344	-0.819	0.858	-2.538	0.901
	Equal variances not assumed			-0.942	45.903	0.351	-0.819	0.869	-2,.567	0.93
Posttest	Equal variances assumed	0.88	0.352	2.179	54	0.034	2.098	0.963	0.168	4.029
	Equal variances not assumed			2.189	53.856	0.033	2.098	0.959	0.177	4.02

An Independent Samples t-Test was conducted to compare Mindfulness pretest scores between the experimental group (M= 33.45, SD=6.423) and control group (M= 31.30, SD= 6.402) as well as posttest scores between the experimental group (M= 33.55, SD=7.239) and control group (M= 32.04, SD= 6.111). The assumption of equal variances was tested using Levene's Test. The result indicated that homogeneity of variance was achieved for the pretest (F= .006, p=0.94), and posttest (F= .885, p=.351). The t-test results showed that assuming equal variances, there was no significant difference in Mindfulness performance between the experimental and control group for the pretest $t(54) = 1.255$, $p = .215$, 95% CI [-1.286, 5.59] and the posttest $t(54) = 1.515$, $p = .403$, 95% CI [-2.088, 5.117]. Therefore, we fail to reject the null hypothesis, indicating that there is insufficient evidence to conclude that the mean scores of Mindfulness for the pretest and posttest differ significantly between

the groups. These results show that the intervention program does not statistically significant impact on Mindfulness scores (Table 20).

Table 20. Independent samples t-test for mindfulness

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	*Sig.*	*t*	*df*	*Sig (2-tailed)*	*Mean Difference*	*Std. Error Difference*	*Lower*	*Upper*
Pretest	Equal variances assumed	0.006	0.94	1.255	54	0.215	2.152	1.715	-1.286	5.59
	Equal variances not assumed			1.255	53.74	0.215	2.152	1.715	-1.286	5.59
Posttest	Equal variances assumed	0.885	0.351	0.843	54	0.403	1.515	1.797	-2.088	5.117
	Equal variances not assumed			0.848	53.508	0.4	1.515	1.786	-2.067	5.096

An Independent Samples t-Test was conducted to determine whether the Self-as-context score difference is statistically significant between experimental and control groups. Means and standard deviations for the Self-as-context score of groups are provided in Table 21.

Table 21. Descriptive statistics for self-as-context scores

Measurement		*M*	*SD*
Pretest	Experimental Group	13.59	3.006
	Control Group	14.19	3.843
Follow-up	Experimental Group	14.93	3.863
	Control Group	13.19	3.952

The assumption of equal variances was tested using Levene's Test. The result indicated that homogeneity of variance was achieved for the pretest (F= 1.84, p=.181), and follow-up (F= 0.063, p=.802). An Independent Samples t-Test results show that before the program there was no statistically significant difference between groups, $t(54) = -0.652$, $p = .517 > .05$. Although the follow-up score of the experimental group is higher than the control group, there is no statistically significant difference between experimental group (M= 14.93,

SD=3.863) and control group (*M*=13.19, *SD*=3.952), [*t*(54) = 1.671, *p* = 0.1], 95% CI [-0.349, 3.84]. These results show that the ACT-based intervention program has no statistically significant impact on Self-as-context after the implementation of the program one month later (Table 22).

Table 22. Independent samples t-test for self-as-context

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	*Sig.*	*t*	*df*	*Sig (2-tailed)*	*Mean Difference*	*Std. Error Difference*	*Lower*	*Upper*
Pretest	Equal variances assumed	1.84	0.181	-0.652	54	0.517	-0.599	0.919	-2.441	1.243
	Equal variances not assumed			-0.646	49.224	0.521	-0.599	0.927	-2.461	1.263
Follow-up	Equal variances assumed	0.063	0.802	1.671	54	0.1	1.746	1.045	-0.349	3.84
	Equal variances not assumed			1.67	53.512	0.101	1.746	1.045	-0.351	3.842

To determine whether there was a significant difference between the experimental and control groups on the psychological flexibility subscales of the applied intervention program, Mann-Whitney U test, one of the nonparametric tests, was applied to the variables that were not normally distributed. In this context, pretest, posttest, and follow-up for the Values subscale; posttest for the Self-as-context subscale; and follow-up test rank averages for Mindfulness and Defusion were compared. In the Self-as-context posttest measurement, a significant difference was detected between the rank averages of the experimental and control groups [*U* = 241, *z* = -2.481, *p* = .013]. Similarly, in the Mindfulness subscale follow-up measurement, a significant difference was detected between the rank averages of the experimental and control groups [*U* = 184.5, *z* = -3.402, *p* = .001]. In the comparison of the experimental and control groups after the ACT-based intervention, Values subscale pretest [*U* = 344.5, *z* = -0.773, *p* =.44], Values subscale posttest [*U* = 275.5, *z* = -1.906, *p* =.057] and follow-up [*U* = 307.5, *z* = -1.38, *p* =.168] and the Defusion subscale follow-up test [*U* = 294.5, *z* = -1.605, *p* =.108], there was no statistically significant difference between the rank averages of the test (Table 23).

Table 23. Mann-Whitney U test results for PFQ scores of the groups

		Group	*N*	*Mean Rank*	*Sum of Ranks*	*U*	*z*
Pretest	Values	E	29	30.12	873.50	344.5	-0.773 (0.44)
		C	27	26.76	722.50		
Posttest	Values	E	29	32.50	942.50	275.5	-1.906 (0.057)
		C	27	24.20	653.50		
	Self-as-context	E	29	33.69	977.00	241	-2.481 (0.013)
		C	27	22.93	619.00		
Follow-up	Values	E	29	31.40	910.50	307.5	-1.38 (0.168)
		C	27	25.39	685.50		
	Mindfulness	E	29	35.64	1033.50	184.5	-3.402 (0.001)
		C	27	20.83	562.50		
	Defusion	E	29	31.84	923.50	294.5	-1.605 (0.108)
		C	27	24.91	672.50		

Within Group Analysis

The results of the normality tests performed in the experimental group for the PFQ pretest, posttest, and follow-up measurement results show that the data obtained from the PFQ Total score, Acceptance, and Defusion subscales are by the normal distribution (p>0.05). Since the Values, Mindfulness, and Self-as-context subscales of the PFQ were found to be p<.05 for at least one of the three different measurements of the experimental group, the assumption of normality was not met in these scales. Therefore, the Friedman test, a nonparametric analysis, was applied for the Values, Mindfulness, and Self-as-context subscales.

Repeated Measures ANOVA was conducted to test whether the experimental group affected the PFQ total score, Defusion, and Acceptance in the pretest, posttest, and follow-up measurements. Repeated Measures ANOVA is used to analyze the differences between measurements when multiple measurements are taken on the same subjects. This type of analysis controls for individual differences between subjects and helps determine whether differences between measurements are significant. Apart from normality and homogeneity, one of the prerequisites for the application of repeated measures analysis of variance (Repeated Measure ANOVA) is to meet the "Sphericity" assumptions (Şengül-Halıcı, 2006). In Repeated Measures ANOVA, the Sphericity assumption is measured by "Mauchly's Sphericity Test". Sphericity assumes that the variances between measurements are equal. When this assumption is not met, corrections must be made for the validity of the test results (Tabachnick & Fidell, 2006). It has been stated that if the measurement result is greater than

the .05 significance level, the sphericity assumption is met, and if it is less than the .05 significance level, the sphericity assumption is not met. Considering this information, Mauchly's Sphericity Test was applied to the PFQ Total and Acceptance in three different time measurements of the experimental group, and in cases where the sphericity assumption was not met, variance analysis results were obtained using the Greenhouse-Geisser correction. Mauchly's Sphericity Test results are given in Table 24.

Table 24. Mauchly's sphericity test results for PFQ total, acceptance and defusion subscale of experimental group

Subscale	*Within Group Effect*	Mauchly's W	χ^2	*df*	*p*	Epsilon	
						Greenhouse-Geisser Correction	Huyn-Feldt Correction
Acceptance	Time	.798	6.077	2	.048	.832	.878
Defusion		.897	2.927	2	.231	.907	.966
Total		.675	10.608	2	.005	.755	.789

According to the results of Mauchly's Sphericity Test, the total score obtained on the PFQ in the experimental group for repeated measurements taken at different times ($W(2) = .675$, $p < .05$) and for Acceptance ($W(2) = .798$, $p < .05$), it does not satisfy the assumption of sphericity. However, the assumption of sphericity was met for the Defusion subscale ($W(2) = .897$, $p > .05$). For this reason, Greenhouse-Geisser Correction results were used when examining the within-group effect for the experimental group regarding the data obtained from PFQ total and Acceptance.

A repeated-measures ANOVA was performed to evaluate the effect of the 8-week intervention program on psychological flexibility. The means and standard deviations for psychological flexibility Total score, Acceptance, and Defusion subscale scores are presented in Table 25.

Table 25. Descriptive statistics for PFQ total score of experimental group

Scale	*Measurement*	*M*	*SD*
PFQ Total	Pretest	135.03	14.379
	Posttest	145.55	19.229
	Follow-up	144.66	16.753
Acceptance	Pretest	17.24	6.098
	Posttest	19.86	7.105
	Follow-up	19.76	6.081
Defusion	Pretest	12.55	2.599
	Posttest	15.17	3.809
	Follow-up	14.97	2.639

Mauchly's test indicated that the assumption of sphericity had been violated for PFQ Total score, $\chi 2$ (2) = .675, p = .005, and therefore Greenhouse-Geisser correction was used. Repeated Measures ANOVA results show that the effect of the intervention program on psychological flexibility was statistically significant at the .05 level, F(1.510, 42.267) = 7.258, p = .004, partial $\eta 2$ = .206 (Table 26)

Table 26. Repeated measures ANOVA results for the PFQ total score, acceptance and defusion scores of the experimental group

	Source		*SD*	*df*	*MS*	*F*	*Sig.*	partial $\eta 2$
PFQ Total	Measurement	Sphericity Assumed	1971.747	2	985.874	7.258	.002	.206
		Greenhouse-Geisser	1971.747	1.510	1306.192	7.258	.004	.206
	Error	Sphericity Assumed	7606.253	56	135.826			
		Greenhouse-Geisser	7606.253	42.267	179.957			
Acceptance	Measurement	Sphericity Assumed	127.747	2	63.874	5.022	.010	.152
		Greenhouse-Geisser	127.747	1.665	76.747	5.022	.015	.152
	Error	Sphericity Assumed	712.253	56	12.719			
		Greenhouse-Geisser	712.253	46.606	15.282			
Defusion	Measurement	Sphericity Assumed	123.126	2	61.563	8.529	.001	.233
		Greenhouse-Geisser	123.126	1.814	67.887	8.529	.001	.233
	Error	Sphericity Assumed	404.207	56	7.218			
		Greenhouse-Geisser	404.207	50.783	7.959			

Post-hoc pairwise comparisons with a Bonferroni correction adjustment indicated that there was a significant difference between the psychological flexibility at the pretest and posttest (*M*=135.03 vs *M*=145.55, respectively, *p*=.006), and psychological flexibility was significantly higher after the intervention of the program than before the intervention. However, there was no statistically significant difference between the posttest and follow-up (Table 27).

Table 27. Repeated measures ANOVA bonferroni results of the PFQ total score of experimental group

Measurement		*SD*	*df*	*MS*	*F*	*Sig.*	partial η2
Time	Pretest vs Posttest	3207.759	1	3207.759	8.751	.006	.238
	Posttest vs Follow-up	23.310	1	23.310	.197	.660	.007
Error	Pretest vs Posttest	10263.241	28	366.544			
	Posttest vs Follow-up	3310.690	28	118.239			

Repeated Measures ANOVA was conducted to determine whether there was a significant difference in the Acceptance subscale total scores of the experimental group pretest, posttest, and follow-up measurements. Descriptive information about the Acceptance score obtained in the pretest, posttest, and follow-up measurements of the experimental group is presented in Table 28. When the sphericity assumption, which is one of the assumptions of Repeated Measures ANOVA, was tested. Mauchly's test indicated that the assumption of sphericity had been violated, $\chi 2$ (2) = .798, p = .048. Since the Acceptance subscale was p<.05, Greenhouse-Geisser and Huynh-Feldt corrections were applied because the Sphericity assumption was violated. Repeated Measures ANOVA determined that mean Acceptance differed significantly across three-time points (F(1.665, 46.606) = 5.022, p = .015, partial η2 = .152). This result reveals that the intervention program showed statistically significant changes over time in the psychological flexibility score in the experimental group. A post-hoc pairwise comparison using the Bonferroni correction showed an increased Acceptance score between the pretest and posttest (*M*=17.24 vs *M*=19.86, respectively, *p*=.026). The increase in the Acceptance score did not reach a statistically significant difference when comparing the posttest to the follow-up assessment taken a month after the end of the intervention program (*M*=19.86 vs *M*=19.76, p = .910). Acceptance score was

significantly higher after the intervention comparing before the intervention. Therefore, we can conclude that the results of the ANOVA indicate a significant time effect for Acceptance as measured for the experimental group (Table 28).

Table 28. Repeated measures ANOVA bonferroni results for acceptance scores of the experimental group

Measurement		*SD*	*df*	*MS*	*F*	*Sig.*	partial η2
Time	Pretest vs Posttest	199.172	1	199.172	5.539	.026	.165
	Posttest vs Follow-up	.310	1	.310	.013	.910	.000
Error	Pretest vs Posttest	1006.828	28	35.958			
	Posttest vs Follow-up	672.690	28	24.025			

Repeated Measures ANOVA was performed to evaluate the effect of the intervention program on Defusion. The means and standard deviations for the Defusion subscale score are presented in Table 29. Mauchly's test indicated that the assumption of sphericity had been met, $\chi 2$ (2) = .897, p = .231. It was determined that the data obtained from the Defusion subscale had equal variances between measurements and met the assumption of sphericity. The effect of the intervention program on Defusion was significant at the .05 level, F(2, 56) = 8.529, p = .001, partial η2 = .233. Post-hoc pairwise comparisons with a Bonferroni correction adjustment showed that there was a significant difference between the Defusion at the pretest and posttest, (M= 12.55 vs M= 15.17, respectively, p = .003). The results show that the Defusion score increased statistically significantly level after the ACT-based intervention program. There is no statistically significant difference between the posttest and follow-up (M= 15.17 vs M= 14.97, respectively, p = .769) (Table 29).

Table 29. Repeated measures ANOVA bonferroni results for the defusion subscale of the experimental group

Measurement		*SD*	*df*	*MS*	*F*	*Sig.*	partial η2
Time	Pretest vs Posttest	199.172	1	199.172	10.708	.003	.277
	Posttest vs Follow-up	1.241	1	1.241	.088	.769	.003
Error	Pretest vs Posttest	520.828	28	18.601			
	Posttest vs Follow-up	394.759	28	14.099			

To evaluate whether the applied intervention created a significant difference in the pretest, posttest, and follow-up measurement in terms of psychological flexibility in the experimental group, the Friedman Test was applied for the Self-as-context, Mindfulness, and Values subscales of the PFQ. The Friedman Test is used to compare ordinal data across multiple dependent samples and determine whether there are significant differences between medians. According to the Friedman test result, there is a statistically significant difference in the Self-as-context subscale of the experimental group between pretest, posttest, and follow-up measurement, x^2 (2) = 9.219, p=.010. However, there is no statistically significant difference in Mindfulness x^2 (2)=1.135 p=.567 and Values subscales x^2(2)=3.944, p=.139. It means that Mindfulness and Values scores did not show a significant difference between the pretest, posttest, and follow-up measurements of the experimental group (Table 30).

Table 30. Friedman test results for the comparison of the PFQ total, self-as-context, mindfulness, values and acceptance subscales of experimental group

Variable	*Measurements*	*Mean Rank*	*df*	x^2	*p*
Self-as-context	Pretest	1.62			
	Posttest	2.38	2	9.219	.010
	Follow-up	2.00			
Mindfulness	Pretest	1.90			
	Posttest	1.95	2	1.135	.567
	Follow-up	2.16			
Values	Pretest	1.76			
	Posttest	2.26	2	3.944	.139
	Follow-up	1.98			

The difference between pretest and posttest measurement of Self-as-context (Z = 2.747, p = .006) is statistically significant for the experimental group. However, there were

no significant differences between the pretest and follow-up (Z = 1.550, p = .121) or between the posttest and follow-up (Z = -1.338, p = .181) (Table 30).

Post-hoc analysis with Wilcoxon signed-rank tests was conducted with a Bonferroni correction applied for the Self-as-context score of the experimental group. The results of the Wilcoxon Signed-Ranks Test compare rank differences between two dependent samples, indicating whether there is a significant difference between medians. The difference between pretest and posttest measurement of Self-as-context (Z = 2.747, p = .006) is statistically significant for the experimental group. However, there were no significant differences between the pretest and follow-up (Z = 1.550, p = .121) or between the posttest and follow-up (Z = -1.338, p = .181) (Table 31).

Table 31. Wilcoxon signed-rank test results for experimental group PFQ and self-as-context subscale

		N	*Mean Rank*	*Sum of Ranks*	*z*
Pretest-Posttest	Negative Ranks	6	12.50	75.00	2.747[*] (.006)
	Positive Ranks	21	14.43	303.00	
	Ties	2			
	Total	29			
Pretest-Follow-up	Negative Ranks	9	11.67	105.00	1.550[b] (.121)
	Positive Ranks	16	13.75	220.00	
	Ties	4			
	Total	29			
Posttest-Follow-up	Negative Ranks	16	13.25	212.00	-1.338[c] (.181)
	Positive Ranks	9	12.56	113.00	
	Ties	4			
	Total	29			

**p<.01*

When all these results were evaluated, the research hypotheses H1.1, H1.2, H1.3, H1.4, H1.5, H1.7, H1.8, H1.9 and H1.11 were accepted, but H1.6, H1.10, and H1.12 were rejected.

3.2.2. Findings Related to the Hypothesis about Emotion Regulation

In this section, the 2nd Hypothesis of the study was tested by comparing the ERQ scores regarding emotion regulation skills of individuals in the experimental and control groups.

Hypothesis 2:

"H2: The ACT-based intervention will result in a significant difference between the experimental and control groups on emotion regulation skills.

H2.1. The ACT-based intervention will result in a significant difference between the experimental and control groups on the Reappraisal score.

H2.2. The ACT-based intervention will result in a significant difference between the experimental and control groups on the Suppression score.

H2.3. The ACT-based intervention will result in a significant difference within the experimental group on Reappraisal scores between the pretest, posttest, and follow-up tests.

H2.4. The ACT-based intervention will result in a significant difference within the experimental group on Suppression scores between the pretest, posttest, and follow-up tests."

Within the scope of the study, emotion regulation was evaluated with scores obtained from the ERQ. When the experimental group was analyzed within itself, it was decided to use parametric tests for the Reappraisal subscale of the ERQ, since the normality assumption was met in three different measurements, but to use nonparametric tests for the Suppression subscale, which did not meet the normality assumption. In the comparison of the experimental and control groups; the Independent Samples t-Test was used to test the H2.1 hypothesis of the study. To test the H2.2 Hypothesis, the Independent Samples t-Test was used for the pretest and follow-up measurements, and Mann-Whitney U test was used for the posttest. Repeated Measures ANOVA was used to test the H2.3 hypothesis of the research and the Friedman test was used to test the H2.4 Hypothesis.

An Independent Samples t-Test was conducted to compare Reappraisal scores for three different time measurements across groups. Pretest scores of experimental group (M=24.24, SD=6.495) and control group (M= 24.41, SD= 7.266), posttest scores of

experimental group (*M*=23.83, *SD*=6.777) and control group (*M*=24.22, *SD*= 5.700) and follow-up scores of experimental group (*M*=25.72, *SD*=5.561) and control group (*M*=24.56, *SD*=5.535) can be seen in Table 32.

Table 32. Descriptive statistics for reappraisal score of the groups

Measurement		*M*	*SD*
Pretest	Experimental Group	24.24	6.495
	Control Group	24.41	7.266
Posttest	Experimental Group	23.83	6.777
	Control Group	24.22	5.700
Follow-up	Experimental Group	25.72	5.561
	Control Group	24.56	5.535

The assumption of equal variances was tested using Levene's Test. The result indicated that homogeneity of variance was achieved for the pretest (*F*=0.934, *p*=.338), posttest (*F*= 0.635, *p*=.429), and follow-up (*F*= 0.005, *p*=.946). It means equal variances are assumed for the test. Independent Samples t-Test showed that before the implementation of the program there was no significant difference in Reappraisal score between experimental and control group $t(54) = -0.09$, $p = .928$, 95% CI [-3.853, 35.21]. There is also no statistically significant difference in Reappraisal scores between the experimental group [$t(54) = -0.235$, $p = 0.815 > .05$, 95% CI [-3.763, 2.973]] at posttest and follow-up [$t(54) = 0.788$, $p = .434 > .05$, 95% CI [-1.806, 4.144]]. The results show that ACT-based programs have no statistically significant impact between groups for the Reappraisal scores both after the intervention and at one-month follow-up measurement (Table 33).

Table 33. Independent samples t-test for reappraisal

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	*Sig.*	*t*	*df*	*Sig (2-tailed)*	*Mean Difference*	*Std. Error Difference*	*Lower*	*Upper*
Pretest	Equal variances assumed	0.934	0.338	-0.09	54	0.928	-0.166	1.839	-3.853	3.521
	Equal variances not assumed			-0.09	52.234	0.929	-0.166	1.847	-3.871	3.539
Posttest	Equal variances assumed	0.635	0.429	-0.235	54	0.815	-0.395	1.68	-3.763	2.973
	Equal variances not assumed			-0.236	53.469	0.814	-0.395	1.669	-3.742	2.953
Follow-up	Equal variances assumed	0.005	0.946	0.788	54	0.434	1.169	1.484	-1.806	4.144
	Equal variances not assumed			0.788	53.75	0.434	1.169	1.484	-1.806	4.143

To compare the suppression score between the experimental and control group an Independent Samples t-Test was conducted for pretest and follow-up scores. Pretest scores of the experimental group (*M*=11.21, *SD*=5.157) and control group (*M*=12.26, *SD*=5.201), and follow-up scores of the experimental group (*M*=11.00, *SD*=4.359) and control group (*M*=12.52, *SD*=5.258) can be seen in Table 34.

Table 34. Descriptive statistics for suppression score of the groups

Measurement		*M*	*SD*
Pretest	Experimental Group	11.21	5.157
	Control Group	12.26	5.201
Follow-up	Experimental Group	11.00	4.359
	Control Group	12.52	5.258

The assumption of equal variances was tested using Levene's Test. The result indicated that homogeneity of variance was achieved for the pretest (*F*=0.089, *p*=.766), posttest (*F*= 0.635, *p*=.429), and the follow-up (*F*=1.071, *p*=.305). Independent Sample t-Test results showed that there was no significant difference in Suppression scores between the experimental and control group before the implementation of the orogram $t(54) = -0.76$, $p = .451 > .05$, 95% CI [-3.829, 1.724]. Similarly, there is no statistically significant difference in suppression scores between groups at follow-up, $t(54) = -1.18$, $p = .243 > .05$, 95% CI [-4.099, 1.062]. The results show that the intervention program did not create a

statistically significant effect in the experimental group compared to the control group in the follow-up measurement one month after the program in terms of suppression score (Table 35).

Table 35. Independent samples t-test for suppression score

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	*Sig.*	*t*	*df*	*Sig (2-tailed)*	*Mean Difference*	*Std. Error Difference*	*Lower*	*Upper*
Pretest	Equal variances assumed	0.089	0.766	-0.76	54	0.451	-1.052	1.385	-3.829	1.724
	Equal variances not assumed			-0.76	53.647	0.451	-1.052	1.385	-3.83	1.725
Follow-up	Equal variances assumed	1.071	0.305	-1.18	54	0.243	-1.519	1.287	-4.099	1.062
	Equal variances not assumed			-1.172	50.659	0.247	-1.519	1.296	-4.12	1.083

In the posttest measurement of the suppression subscale, no significant difference was detected between the rank averages of the experimental and control groups [U = 323, z = -1.121, p = .262]. Mann-Whitney U test results are presented in Table 36.

Table 36. Mann-Whitney U test results for suppression subscale posttest scores of the groups

	Group	*N*	*Mean Rank*	*Sum of Ranks*	*U*	*z*
Posttest	E	29	26.16	758.50	323.5	-1.121
	C	27	31.02	837.50		(0.262)

Repeated Measures ANOVA was conducted to determine whether there was a significant difference in the Reappraisal subscale total scores of the experimental group pretest, posttest, and follow-up. The averages and standard deviations of the Reappraisal score obtained in the pretest, posttest, and follow-up measurements of the experimental group are presented in Table 37.

Table 37. Descriptive statistics for reappraisal subscale of experimental group

Measurement	*M*	*SD*
Pretest	24.24	6.495
Posttest	23.83	6.777
Follow-up	25.72	5.561

Mauchly's Sphericity Test was applied to test the sphericity assumption, which is one of the assumptions of Repeated Measures ANOVA. The results showed that for repeated measurements taken at different times, the assumption of sphericity was met for the total score obtained from the Reappraisal subscale in the experimental group (W (2) = .999, p > .05) (Table 38).

Table 38. Mauchly's sphericity test results for the experimental group reappraisal

Subscale	*Within Subjects Effect*	Mauchly's W	χ^2	*df*	*p*	Epsilon	
						Greenhouse-Geisser Correction	Huyn-Feldt Correction
Reappraisal	Time	.999	.019	2	.991	.999	1.000

Repeated Measures ANOVA determined that the mean of Reappraisal did not differ significantly across three-time points (F(2, 56) = 1.203, p = .308, partial η2 = .041). This result reveals that the intervention program did not show statistically significant changes over time in the reappraisal score in the experimental group (Table 39).

Table 39. Repeated measures ANOVA results for the reappraisal scores of the experimental group

Source		*SD*	*df*	*MS*	*F*	*Sig.*	partial η2
Measurement	Sphericity Assumed	57.678	2	28.839	1.203	.308	.041
Error	Sphericity Assumed	1342.322	56	23.970			

To evaluate whether the intervention created a significant difference in the pretest, posttest, and follow-up measurements in terms of Suppression in the experimental group, the Friedman test was applied. According to the Friedman test result, there is no statistically significant difference in Suppression in three different measurements of the experimental group (Table 40).

Table 40. Friedman test results for suppression scores of the experimental group

Variable	*Measurements*	*Mean Rank*	*df*	x^2	*p*
Suppression	Pretest	2.14	2	2.554	.279
	Posttest	1.78			
	Follow-up	2.09			

Based on these results, H2.1., H2.2., H2.3. and H2.4. hypotheses were rejected.

3.2.3. Findings Related to the Hypothesis about Depression Anxiety and Stress

In this section, the 3rd Hypothesis of the study was tested by comparing the DASS scores regarding the depression, anxiety, and stress levels of individuals in the experimental and control group

Hypothesis 3:

"H3: The ACT-based intervention will result in a significant difference between the experimental and control groups on Depression, Anxiety, and Stress levels.

H3.1. The ACT-based intervention will result in a significant difference between the experimental and control groups on Depression scores.

H3.2. The ACT-based intervention will result in a significant difference between the experimental and control groups on Anxiety scores.

H3.3. The ACT-based intervention will result in a significant difference between the experimental and control groups on Stress scores.

H3.4. The ACT-based intervention will result in a significant difference within the experimental group on Depression scores between the pretest, posttest, and follow-up tests.

H3.5. The ACT-based intervention will result in a significant difference within the experimental group on Anxiety scores between the pretest, posttest, and follow-up test.

H3.6. The ACT-based intervention will result in a significant difference within the experimental group on Stress scores between the pretest, posttest, and follow-up test."

Within the scope of the study, depression, anxiety, and stress were evaluated with scores obtained from the DASS. Since the Depression, Anxiety, and Stress subscale of the DASS did not meet the assumption of normality in three different measurements, it was decided to use nonparametric tests. In this context, the Mann-Whitney U test was used to make a comparison between the experimental and control groups to test the H3.1, H3.2, and H3.3 hypotheses of the research. On the other hand, H3.4, H3.5. and H3.6, the Friedman test was used to compare the measurements within the experimental group at different times.

According to the Mann-Whitney U test results, the depression, anxiety, and stress test rank averages of the DASS of the experimental and control groups were compared. Depression [U = 358.5, z = -0.543, p =.587], Anxiety [U = 283, z = -1.793, p =.073], and stress [U = 360.5, z = -0.509, p=.061] of the experimental and control groups, no significant difference was detected between the rank averages of the pretest scores. However, in the Depression posttest measurement, a significant difference was detected between the rank averages of the experimental and control groups [U = 263, z = -2.125, p = .034], while there was no significant difference between the rank averages of the follow-up measurement scores [U = 387, z = -0.075, p = .094]. A significant difference was detected between the rank averages of both the posttest [U = 252, z = -2.326, p =.02] and follow-up measurements [U = 272, z = -2.003, p =.045] in the Anxiety measurement of the experimental and control groups. On the other hand, in the comparison of the experimental and control groups after the ACT-based intervention, both posttest [U = 312, z = -1.309, p = .19] and follow-up measurements [U = 379.5, z = -0.198, p = .843] in stress measurement, no statistically significant difference was detected between the averages (Table 41).

Table 41. Mann-Whitney U test results for DASS scores

		Group	*N*	*Mean Rank*	*Sum of Ranks*	*U*	*z*
	Depression	E	29	29.64	859.50	358.5	-0.543
Pretest							(0.587)
		C	27	27.28	736.50		
	Anxiety	E	29	24.76	718.00	283	-1.793
		C	27	32.52	878.00		(0.073)
	Stress	E	29	29.57	857.50	360.5	-0.509 (0.61)
		C	27	27.35	738.50		
Posttest	Depression	E	29	24.07	698.00	263	-2.125
							(0.034)
		C	27	33.26	898.00		
	Anxiety	E	29	23.69	687.00	252	-2.326(0.02)
		C	27	33.67	909.00		
	Stress	E	29	25.76	747.00	312	-1.309 (0.19)
		C	27	31.44	849.00		
Follow-up	Depression	E	29	28.34	822.00	387	-0.075
							(0.094)
		C	27	28.67	774.00		
	Anxiety	E	29	24.38	707.00	272	-2.003
		C	27	32.93	889.00		(0.045)
	Stress	E	29	28.09	814.50	379.5	-0.198
		C	27	28.94	781.50		(0.843)

According to the Friedman test results, there is a statistically significant difference in Anxiety subscale x^2 (2) =10.308, p=.006 among the three different measurements of the experimental group. However, there is no statistically significant difference in Depression x^2 (2) =4.374, p=.112, and Stress subscales x^2(2)=4.941, p=.085. It means that the applied program did not create a statistically significant difference in terms of depression and stress in the pretest, posttest, and follow-up test of the experimental group, but it did create a statistically significant difference in terms of anxiety (Table 42).

Table 42. Friedman test results for DASS scores of the experimental group

Variable	*Measurements*	*Mean Rank*	*df*	x^2	*p*
Depression	Pretest	1.62	2	4.374	.112
	Posttest	2.38			
	Follow-up	2.00			
Anxiety	Pretest	2.43	2	10.308	.006
	Posttest	1.78			
	Follow-up	1.79			
Stress	Pretest	1.76	2	4.941	.085
	Posttest	2.26			
	Follow-up	1.98			

Post-hoc analysis with Wilcoxon Signed-Rank Tests was conducted with a Bonferroni correction applied to the Anxiety score of the experimental group. The results of the Wilcoxon Signed-Ranks Test compare rank differences between two dependent samples,

indicating whether there is a significant difference between medians. Within the experimental group, Anxiety values are statistically different between the pretest and follow-up measurement (Z= 2.303, p = .021). On the other hand, there were no significant differences between the pretest and posttest measurement (Z = -1.928, p = .054) and posttest and follow-up (Z = -.287, p = .774) (Table 43).

Table 43. Wilcoxon signed-rank test results for anxiety of experimental group

		N	*Mean Rank*	*Sum of Ranks*	*z*
Pretest-Posttest	Negative Ranks	17	11.82	201.00	-1.928
	Positive Ranks	6	12.50	75.00	(.054)
	Ties	6			
	Total	29			
Pretest-Follow-up	Negative Ranks	19	12.11	230.00	-2.303*
	Positive Ranks	5	14.00	70.00	(.021)
	Ties	5			
	Total	29			
Posttest-Follow-up	Negative Ranks	8	9.88	79.00	-.287
	Positive Ranks	10	9.20	92.00	(.774)
	Ties	11			
	Total	29			

**p<.05*

Based on these results, the H3.1, H3.2, and H3.4 hypotheses of the study were accepted, but the H3.3, H3.5, and H3.6 hypotheses were rejected.

3.2.4. Findings Related to the Hypothesis about Parenting

In this section, the fourth Hypothesis of the study was tested by comparing the APQ scores regarding the parenting skills of individuals in the experimental and control groups.

Hypothesis 4:

"H4: The ACT-based intervention will result in a significant difference between the experimental and control groups on Positive Parenting skills.

H4.1. The ACT-based intervention will result in a significant difference between the experimental and control groups on Positive Parenting scores.

H4.2. The ACT-based intervention will result in a significant difference between the experimental and control groups on Childcare scores.

H4.3. The ACT-based intervention will result in a significant difference within the experimental group on Positive Parenting scores between the pretest, posttest, and follow-up tests.

H4.4. The ACT-based intervention will result in a significant difference within the experimental group on Childcare scores between the pretest, posttest, and follow-up test."

Within the scope of the study, parenting skills were evaluated with the scores obtained from the APQ. When the experimental and control groups were compared, it was decided to use parametric tests for the Childcare subscale of the APQ, as it provided the assumption of normality in the posttest and follow-up measurement, but to use nonparametric tests for the pretest measurement of the Childcare subscale pretest and the Positive Parenting subscale, which did not provide the assumption of normality. In this context, the Mann-Whitney U test was used to test the H4.1 hypothesis of the study, and the Independent Samples t-Test was used to test the posttest and follow-up measurement of the H4.2 hypothesis. Friedman test was used to test the H4.3 hypotheses of the research and Repeated Measures ANOVA was used to test the H4.4 hypothesis.

There was no significant difference between the mean rank scores of the Positive Parenting pretest scores of the experimental and control groups [U = 320, z = -1.182, p = .237]. According to the Mann-Whitney U test results, the Positive Parenting test posttest [U = 365, z = -0.437, p = .662] and follow-up test [U = 314, z = -1.272, p = .203] scores of the experimental and control groups were ranked in order. It was observed that there was no significant difference between the averages (Table 44).

Table 44. Mann-Whitney U test results for positive parenting subscale scores

		Group	*N*	*Mean Rank*	*Sum of Ranks*	*U*	*z*
Pretest	Positive Parenting	E	29	26.03	755.00	320	-1.182 (.237)
		C	27	31.15	841.00		
Posttest	Positive Parenting	E	29	27.59	800.00	365	-0.437 (0.662)
		C	27	29.48	796.00		
Follow-up	Positive Parenting	E	29	31.16	903.50	314.5	-1.272 (0.203)
		C	27	25.65	692.50		

To compare Childcare posttest and follow-up scores between experimental and control groups an Independent Samples t-Test was conducted. Posttest scores of the experimental group (*M*=40.45, *SD*=5.980) and control group (*M*=41.33, *SD*=5.371), and follow-up scores of the experimental group (*M*=41.17, *SD*=6.487) and control group (*M*=40.78, *SD*=4.627) can be seen in Table 45.

Table 45. Descriptive statistics for childcare scores

Measurement		*M*	*SD*
Posttest	Experimental Group	40.45	5.980
	Control Group	41.33	5.371
Follow-up	Experimental Group	41.17	6.487
	Control Group	40.78	4.627

The assumption of equal variances was tested using Levene's Test. The result indicated that homogeneity of variance was achieved for the posttest (F = 0.187, p = .667). There is a significant difference in variances for the follow-up score of the Childcare subscale (F=4.516, p=0.038) meaning equal variances are not assumed. An Independent Sample t-Test results showed that there was no statistically significant difference in Childcare scores between the experimental and control group at the posttest $t(54)$ =-0.581, p =. 564>.05, 95% CI [-3.938, 2.168], and at the follow-up $t(54)$ = 0.263, p = .793>.05, 95% CI [-2.613, 3.402]. The results confirm that the intervention program did not create a statistically significant effect in the experimental group compared to the control group in the posttest and follow-up measurement in terms of Childcare score (Table 46).

Table 46. Independent samples t-test on childcare scores

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	*Sig.*	*t*	*df*	*Sig (2-tailed)*	*Mean Difference*	*Std. Error Difference*	*Lower*	*Upper*
Posttest	Equal variances assumed	0.187	0.667	-0.581	54	0.564	-0.885	1.523	-3.938	2.168
	Equal variances not assumed			-0.583	53.936	0.562	-0.885	1.517	-3.927	2.156
Follow-up	Equal variances assumed	4.516	0.038	0.26	54	0.796	0.395	1.516	-2.644	3.434
	Equal variances not assumed			0.263	50.67	0.793	0.395	1.498	-2.613	3.402

To evaluate whether the applied intervention created a significant difference in the pretest, posttest, and follow-up measurements in terms of Positive Parenting in the experimental group, the Friedman test was applied. According to the Friedman test result, there is no statistically significant difference in Positive Parenting $x^2(2)=1.857$, $p=.395$ in three different measurements of the experimental group. This means that the experimental group of the intervention program showed no statistically significant difference in Positive Parenting at the pretest, posttest, and follow-up test (Table 47).

Table 47. Friedman test results for positive parenting scores of the experimental group

Variable	*Measurements*	*Mean Rank*	*df*	x^2	*p*
Positive Parenting	Pretest	1.84	2	1.857	.395
	Posttest	1.98			
	Follow up	2.17			

Repeated Measures ANOVA was conducted to determine whether there was a significant difference in the Childcare subscale in the experimental group pretest, posttest, and follow-up measurements. Descriptive statistics regarding the Childcare score of the experimental group obtained at three different time measurements are presented in Table 48.

Table 48. Descriptive statistics for childcare subscale of experimental group

Measurement	*M*	*SD*
Pretest	40.07	5.593
Posttest	40.45	5.980
Follow-up	41.17	6.487

Mauchly's Sphericity Test was applied to test the sphericity assumption, which is one of the assumptions of Repeated Measures ANOVA. The results showed that Mauchly's test indicated that the assumption of sphericity had been violated, $\chi 2\ (2) = .675$, $p = .005$. For this reason, Greenhouse-Geisser Correction results were used when examining the within-group effect for the experimental group regarding the data obtained from Childcare subscale (Table 49).

Table 49. Mauchly's sphericity test results for childcare subscale

Subscale	*Within Subjects Effect*	Mauchly's W	χ^2	*df*	*p*	Epsilon	
						Greenhouse-Geisser	Huyn-Feldt
Childcare	Time	.621	12.854	2	.002	.725	.755

Repeated Measures ANOVA determined that the mean of Childcare did not differ significantly across three-time points, F (1.451, 40.616) = .906, p = .383, partial η2 = .031. (Table 50). This result reveals that the intervention program did not show statistically significant changes over time on the Childcare score in the experimental group.

Table 50. Repeated measures ANOVA results for childcare subscale of the experimental group

Source		*SD*	*df*	*MS*	*F*	*Sig.*	Partial η2
Measurement	Sphericity Assumed	18.230	2	9.115	.906	.410	.031
	Greenhouse-Geisser	18.230	1.451	12.568	.906	.383	.031
Error	Sphericity Assumed	563.103	56	10.055			
	Greenhouse-Geisser	563.103	40.616	13.864			

Based on these results, H4.1, H4.2, H4.3, and H4.4 hypotheses of the research were rejected.

4. DISCUSSION

In this section, the findings obtained from the descriptive statistics and the testing of the hypotheses are interpreted in the light of the relevant literature. The strengths and limitations of the research are discussed.

4.1. Evaluation of Findings Obtained from Descriptive Statistics

Almost all the participants were adult women in the current study, there were just two male participants, one in the experimental group and one in the control group. It is a common problem both in Türkiye and all around the world that male participation in studies conducted with divorced parents is low (Akturk, 2023; Aktas; Ardeshirzadeh et al., 2022; Mahmoudpour 2021; Quchani 2021). According to National Education Statistics, the rate of women aged 25 and over who are graduates of faculties, master's, and doctoral degrees in Türkiye is reported as 21.6% in 2022 (TUIK, 2023). In the current study, the education level of the participants is above the average. As the educational level of divorced people increases, possibilities of encountering economic difficulties decrease (Aktas, 2011; Akturk, 2023) and they become more successful and willing to establish a new life (Akturk, 2023). There is a positive relationship between the educational status of divorced people and the quality of life (Sezer & Gurgan, 2018). Being educated contributes to feeling independent and having easier post-divorce adjustment as it increases job opportunities and economic conditions (Cimen, 2023).

In the current study, most of the participants, the majority of whom are women, are working and that most of them are public personnel, mostly teachers. According to national data of Türkiye, 30.4% of the female population aged 15 and over is employed. (TUIK, 2023). In terms of employment status, the current sample is considered above the country average. Data on women's employment status before the divorce shows that approximately half of the women were working before the divorce, and although a small number of them quit working after the divorce, more of them started to work. In other words, the people who have increased economic responsibilities because of divorce started to work has increased. This situation is consistent with the information in the literature that some people start working to meet economic needs or feel economically stronger after the divorce, while

others need to quit working because of the responsibilities related to childcare (Akturk, 2023). The adaptation level of divorced working people is found to be significantly higher than those who are not working (Cimen, 2023). In the study of Akoglu and Kucukkaragoz (2018), it is seen that after the divorce the problem rates of finding housing, emotional distress, and environmental and family pressure are lower for those who have economic welfare compared to those who express financial difficulties. Based on this, it can be understood that employment is not only limited to improving economic conditions but also increases the quality of life in the post-divorce period.

It is seen that most of the participants have been married for more than six years. According to the national divorce statistics, of the divorces in 2023, 33.4% occurred in the first five years of marriage, 21.7% occurred within 6-10 years of marriage, and 15.8% occurred within 11-15 years of marriage (TUIK, 2023). The difference with the current study findings can be understood considering that the current study has the inclusion criterion of having children between the ages of 6-18. To look at the decision of divorce, it is seen that approximately half of the participants (53.6%) stated that they made the decision, 23.2% stated that they made a joint decision, and only 12.5% stated that the decision was made by the other spouse. According to the results of the Research on Causes of Divorce conducted in Türkiye, most women are the first to file a lawsuit during the divorce process (Demirkan et al., 2009; Saglam & Aylaz, 2017). Considering that almost all the participants of the study consist of women, the findings are found to be consistent with the literature. When the findings are evaluated in terms of alimony, 78.58% of the participants received child support, followed by poverty alimony and temporary alimony. Some participants (16.1%) reported receiving no child support. It is also observed that almost all the participants (54 people, 96.4%) did not pay any alimony. There are no specific publicly available statistics regarding the rate of alimony in Türkiye to compare the current findings.

When the findings are evaluated in terms of custody status, it is seen that a significant majority of the participants reported that the mothers had custody of the children (80.4%). Of the participants, 14.3% stated that they have joint custody. It is also seen that most of the children (91.1%) live with the mother, while only 3.6% of the children live with the father. Current findings support the literature that the custody and care responsibility of children after divorce mostly belongs to the mother (Akturk, 2023; Ugur, 2014). In Türkiye, custody

of the child is mostly given to the mother, except for reasons such as the mother leaving the house, deception, and inadequate financial conditions (Feyzioglu & Kuscuoglu, 2011). Akturk (2023) has interviews with divorced mothers and reports that if women do not have custody of their children after the divorce due to economic inadequacy, this situation results in women being negatively affected (Akturk, 2023).

Participants reported that divorce affect in several ways respectively: the living house, domestic order, health, relationships with children, jobs, and relationships with friends. Only one person reported that no aspect of her life was affected. In studies conducted in Türkiye, it is stated that the main difficulties faced by women after divorce are economic, problems in business life, childcare, psychological pressure, and distress (Akturk, 2023). It is also supported by another study results that divorced mothers mostly experience economic difficulties, emotional problems, and changes in routine after the divorce (Sancaklı, 2014). Although the options offered to participants in the studies are different, this information is compatible with the results of the current study. In this research, the options for psychological difficulties and economic difficulties were not provided. To evaluate the finding in terms of social support after the divorce, the sample group stated that they received social support mostly and respectively from their siblings, mothers, friends, fathers, relatives, and children. Six of the participants (10.7%) stated that they did not receive social support from anyone. Social support during and after the divorce helps to overcome challenging processes more easily and manage the process effectively (Amato, 2000). Social support after divorce positively and significantly predicts the level of post-divorce adjustment (Cimen, 2023). However, unfortunately, some divorced women do not receive any support from their families after the divorce process (Akturk, 2023). The findings obtained from the current study are also compatible with the literature in a way that although divorced people receive support mostly from family members and friends, this is not the case for everyone. Within the scope of this study, people were asked about receiving psychological support during or after the divorce process. It was determined that very few of them received psychological support, and most of them had counseling support on how to share the divorce decision with their children. Findings support the literature. However, when divorced women are asked to list the services needed during and after the divorce, the list mostly consists of psychological, economic, and legal support, respectively (Akturk, 2023).

4.2. Evaluation of the Findings Obtained from Testing the Hypotheses

4.2.1. Evaluations Regarding the Hypothesis about Psychological Flexibility

The first hypothesis of the study is "The ACT-based intervention will result in a significant difference between experimental and control groups on psychological flexibility." The result of the analysis shows that the experimental group demonstrated higher psychological flexibility compared to the control group. These results suggest that the ACT-based intervention effectively increases overall psychological flexibility levels between groups. The intervention program significantly increased the total psychological flexibility score within the experimental group within three different measurement times. A significant increase between the pretest and posttest is detected.

When the results are evaluated in terms of the sub-dimensions of psychological flexibility, to look at the change in the acceptance level between groups, a significant difference favoring the experimental group was found immediately after the intervention. No significant differences were observed between groups in the follow-up measurement. These findings imply that while the ACT-based group intervention has short-term effects on acceptance, its long-term sustainability needs further exploration. When we look at the change in the level of acceptance within the experimental group, there was a significant increase in the acceptance level after the intervention program. This suggests that the intervention program increases acceptance, and this effect is maintained during the follow-up. The results of defusion, which is another sub-dimension of psychological flexibility showed that there is a significant difference favoring the experimental group against the control group immediately after the intervention. It means that the ACT-based program helps individuals defuse challenging thoughts and emotions. Also, within the experimental group, there was a significant increase in the defusion level between the pretest and posttest. This proves that the intervention program significantly increases defusion levels, and this effect is sustained over the follow-up period. On the other hand, the self-as-context level did not significantly differ between the groups. However, there was a significant difference in the self-as-context level between the pretest and posttest measurements of the experimental group. This suggests that the intervention program has a short-term positive effect on self-as-context, this effect diminishes over time.

In addition to all these positive effects, the impact of the program on some sub-dimensions of psychological flexibility was not found to be statistically significant. Firstly, there were no statistically significant differences in mindfulness levels between the experimental and control groups. It suggests that the intervention does not have a significant impact on mindfulness. Although there was a noticeable increase in mindfulness scores within the experimental group between pretest and follow-up, this increase did not turn out to be statistically significant. Mindfulness scores also did not show a significant difference across the pretest, posttest, and follow-up measurements of the experimental group. Lastly, although there was an increasing trend towards differences between the groups in terms of values, it did not reach statistical significance. It implies that the intervention program does not create a significant change between groups in terms of the determination of personal values and increasing contact with them. While comparing the values scores of the experimental group across different measurements, although there appears to be a noticeable increase between pretest and posttest, and pretest and follow-up, this increase was not found to be statistically significant. Therefore, it can be concluded that the ACT-based group intervention program does not have a statistically significant effect on the values over time.

It will be beneficial to evaluate all these findings with the related literature both for psychological flexibility and for the concepts that constitute psychological flexibility. Firstly, the current findings regarding psychological flexibility that ACT increases psychological flexibility are supported by Byrne et al., 2020, Caimano et al., 2024, Cansız et al., 2020, Demirci-Seyrek and Ersanlı, 2017, Graham et al., 2016, Gumus 2020, Koksal 2023, Levin et al., 2012, Ruiz et al., 2010, Shankar, 2014 and Tohumcu, 2024. Additionally, the results of this study are consistent with the findings of Mikaili and Sharifi (2017), who reported that the ACT-based intervention program led to a significant increase in psychological flexibility in divorced individuals. Many research articles and literature reviews examining the effect of ACT interventions on psychological flexibility consistently prove a positive effect on psychological flexibility which is, in fact, the basis of ACT. No studies have been found in the literature suggesting that ACT reduces psychological flexibility. It would be useful to elucidate these results regarding psychological flexibility and interpret benefits for divorced parents. Psychological flexibility which means the ability to manage emotions and exhibit appropriate behavior in stressful situations plays a vital role in social functioning (Hayes et al., 2006). Flexibility not only refers to the ability of individuals to withstand challenging situations but also to actively develop positive reactions

to these situations. ACT aims to increase psychological flexibility by accepting negative emotions and thoughts rather than avoiding them, committing to personal values and goals, and fostering mindfulness and present-moment awareness. Divorced individuals, particularly women, exhibit low psychological flexibility (Hamid et al., 2011). ACT-based interventions can increase resilience and reduce psychological symptoms by increasing the awareness of divorced people through strategies such as accepting emotions, living in the moment, and observing without judgment (Ghorbani Amir et al., 2019). In this respect, increasing psychological flexibility enables divorced people to be resilient in the face of stressful and traumatic events they are exposed to before, during, and after the divorce. It also helps them to develop a positive post-divorce adjustment process by learning and growing from previous events. At this point, developing psychological flexibility is of great importance for both the mental health and general well-being of divorced individuals (Mikaili & Sharifi, 2014).

Secondly, the result that the ACT-based intervention increases acceptance supports the literature. It is proven that ACT improves acceptance of challenging and unwanted emotions in many studies (Ghorbani Amir et al., 2019; Graham et al., 2016; Hayes et al., 2011; Levin et al., 2012; McCracken & Gutierrez-Martinez, 2011, Powers et al., 2009; Tohumcu, 2024; Usta, 2017). The findings are also consistent with the finding of Mikaili and Sharifi (2014) that ACT develops acceptance for divorced people. There is no study in the literature that provides evidence that ACT reduces acceptance. It can be explained by the fact that acceptance is the significant and basic mechanism of ACT. However, Arch and Craske (2008), discuss the effects of ACT and CBT on different anxiety disorders and suggest that the expected increase in acceptance may not be achieved in certain populations or certain contexts. The findings of the current study do not support Arch and Craske (2008). The success of ACT in improving acceptance may be due to the approach it offers to change relationships with internal experiences and increase psychological flexibility in dealing with emotional difficulties. ACT encourages individuals to fully recognize and experience emotions, whether positive or negative, pleasant or unpleasant. People whose marital relationship is broken up or divorced intensely experience various emotions such as sadness, anger, panic, loneliness, and hatred (Hamid et al., 2011). ACT suggests willingness and acceptance rather than avoiding challenging emotions. People, who learn to make room for unwanted emotions instead of running away, reduce experiential avoidance, increase flexibility, and cope with stressful situations more effectively. Becoming more resilient by

facing difficult emotional experiences is an important component of post-divorce adjustment (Ardeshirzadeh et al., 2022). Additionally, stopping to control and fight over unpleasant or uncontrollable internal experiences makes those experiences seem less uncontrollable. In this way, the person directs attention to observe mental events which provide insight (Ghorbani Amir et al., 2019). Observing internal experiences without judgment and staying engaged in them despite emotional discomfort, leads to better psychological adjustment and overall well-being (Najjari, 2017).

Thirdly, findings related to the defusion are consistent with the results of the study by Ardeshirzadeh et al. (2022), Cansız et al. (2020), Demirci-Seyrek and Ersanlı (2017), Ghorbani Amir et al. (2019), Hayes et al. (2011), Levin et al. (2012), Masuda et al. (2004), Mikaili and Sharifi (2014), Tohumcu (2024) which suggests that ACT increases defusion and helps individuals develop a more flexible and accepting attitude towards challenging thoughts. There is no academic study in the literature proving that ACT reduces defusion. However, the study of Corti et al. (2018) with parents of children with autism spectrum disorder resulted in a statistically nonsignificant change in defusion. The study of Tani et al. (2013) with parents of children with developmental disabilities also reported that ACT did not cause any statistically significant change in defusion. In explaining the findings, in ACT interventions, individuals are taught not to evaluate thoughts as reality but merely as thoughts in the mind. It contributes individuals to reorganizing relationships with thoughts and reduces the impact of negative thoughts and emotions (Ardeshirzadeh et al., 2022). Instead of engaging in a struggle with thoughts, it encourages accepting them as they are. In this respect, ACT aims to help individuals perceive thoughts as less concrete and less threatening (Hayes et al., 2006). Additionally, cognitive defusion helps divorced people become less emotionally damaged by self-blaming, inadequacy, and negative thoughts regarding the end of a marriageor experiences during the marriage process, (Masuda et al., 2004).

Fourthly, in this study, the self-as-context scores of the experimental group increased after the intervention, but this significant difference within the group was not observed when compared with the control group. In this respect, the findings support both studies suggest that ACT is effective on self-as-context (Bach & Moran, 2008; Flaxman et al., 201; Harris et al., 2009; Tohumcu, 2024) and studies suggest that it is partially effective (Gloster et al., 2020; Katajavuori et al., 2023). Katajavuori et al. (2023), demonstrated that although ACT

intervention is effective in improving general well-being and reducing depression and anxiety of university students, it has no statistically significant effect in terms of increasing self-as-context. In addition, Gloster et al. (2020), reviewed 20 meta-analyses and 133 studies related to ACT interventions. They reported the positive effects of ACT for a broad range of target conditions and psychological problems, but inconsistent effects were observed on the concept of self-as-context. These controversial findings suggest that while ACT can be beneficial for psychological well-being in a wide range, its effectiveness in increasing self-as-context might be limited under certain conditions. ACT aims to evaluation of the self in the context that the experiences occur, rather than defining the self according to experiences or concepts. By moving away from self-narratives and evaluating the self objectively, people may realize that the self extends beyond the evaluations, experiences, thoughts, or feelings. Awareness and self-understanding exercises in the intervention aim to create a more flexible self, rather than getting fused with thoughts and feelings. Contact with the contextual self contributes to psychological flexibility and resilience, and therefore to general well-being (Harris et al., 2006). Divorced people inevitably exposed to changes in living place of residence, job, and spouse role may lead to a negative perception of the self. With the self-observer exercises, the observer realizes that the self is permanent even if the environment and roles change leading to effective coping in challenging situations (Bach & Moran, 2008).

The results of the study related to mindfulness revealed that the experimental group showed a positive effect compared to the control group, but although the mindfulness level between different measurements of the experimental group increased. However, the difference did not come up with a statistically significant. In this respect, findings are somehow consistent with studies that prove that ACT intervention increases mindfulness skills (McCracken & Gutierrez-Martinez, 2011; Rasanen et al., 2016; Tohumcu, 2024). To elaborate on these findings, individuals may experience problems focusing on the moment or lose touch with the moment while trying to control emotions, thoughts, and events or while avoiding challenging situations. Therefore, ACT encourages individuals to live in the present moment and become aware of physical sensations and inner experiences. Individuals who develop awareness by focusing on breathing lead to experience emotional acceptance and inner peace. Mindfulness allows individuals to manage emotional reactions more consciously and effectively cope with stressful situations (Ardeshirzadeh et al., 2022). During the group sessions, mindfulness exercises were included from the first session to the last session, to increase the ability to stay in the present. It is believed that the ability to stay

in the present contributes to increasing the psychological flexibility of divorced individuals by keeping them away from the worries of the future and the grief of the past. On the other hand, the fact that no statistically significant increase was detected within the experimental group can be attributed to the fact that the participants may have used mindfulness exercises for different functions. Bacon et al. (2014) state that people have difficulty making sense of some of the concepts of ACT and struggle with them, especially with the concept of mindfulness. People may use ACT exercises to improve mindfulness as a form of distraction rather than creating space for emotions and thoughts (Bacon, et al., 2014; Bloy, 2013; Wardley et al., 2014; Williams et al., 2014). This misuse outside of the purpose paradoxically fosters negative emotions, thoughts, and avoidance strategies (Cioffi & Holloway, 1993; Wegner, 1994). Additionally, mindfulness exercises can be challenging in terms of paying enough attention, especially if people are under stress. This difficulty is associated with the fact that people under stress are overwhelmed in managing attention because of overloaded cognitive systems. For this reason, in ACT-based group interventions, people being highly distressed may hold themselves back from the benefit of functional aspects of the therapy, especially in improving mindfulness (Smith, 2017).

Lastly, although there was no statistically significant difference in the values between and within group comparisons, it should not be ignored that there was a visible increase within the experimental group. Findings for the values are inconsistent with some studies suggesting that ACT is significantly effective in determining personal values and fulfilling committed actions (Ciarrochi et al., 2010; Harris, 2009; Hayes et al., 2006; Tohumcu, 2024; Twohig & Crosby 2010). These findings are consistent with studies suggesting that ACT is not always effective in enhancing values, as in some cases, it produces non-significant results; therefore, further research is needed on this topic (Corti et al., 2018; Engle & Follette, 2018; Paliliunas, 2022; Tani et al., 2013). Committed actions in line with personal values are an important component of ACT. ACT emphasizes the importance of behavioral change through committed actions, while eliminate avoiding challenging or unpleasant experiences. ACT may be useful for divorced parents to manage a range of challenges by combating experiential avoidance and cognitive fusion (Coyne et al., 2011). For example, a divorced parent who is solely focused on experiential avoidance may remain stuck in this cycle by concentrating on managing or suppressing the psychological pain associated with being divorced or the challenges of being a single parent, rather than taking actions aligned with personal values. However, a parent who realizes personal values and takes action in line with

them will be able to cope with the difficulties easily thanks to the willingness to prevent them. It is noteworthy that although there were, in some measurements, positive effects on all sub-dimensions of psychological flexibility within the scope of this study, no statistically significant effect was seen on the values both within and between the subject analysis. This situation can be explained in several ways. Values and committed actions were addressed as the final component of psychological flexibility in the last two sessions. Therefore, participants may not have had enough motivation or time for this component to be sufficiently nourished and developed. Although the different exercises and practices performed in these sessions raise awareness about values, determining personal values is associated with existential awareness and taking action in line with this awareness. The challenging life conditions and stress that participants experience because of divorce or post-divorce adjustment may lead them the challenging ways of coping with existential issues, clarifying personal values, and prompting towards committed actions.

4.2.2. Evaluations Regarding the Hypothesis about Emotion Regulation

The second hypothesis of the study is "The ACT-based intervention will result in a significant difference between the experimental and control group on emotion regulation skills." The intervention program did not result in a statistically significant change in suppression scores for the experimental group compared to the control group. Within-subject analysis results suggested that there is no statistically significant difference in suppression scores at the pretest, posttest, and follow-up within the experimental group. The results regarding reappraisal showed that there is no significant difference in reappraisal scores between the experimental and control groups. The ACT-based program did not have a statistically significant impact on the reappraisal scores of experimental groups when comparing pretest, posttest, and follow-up. Findings imply that an ACT-based group intervention program is not effective for divorced parents to reduce suppression or improve reappraisal. These findings are inconsistent with studies suggest that ACT improves emotion regulation (Ghorbani Amir et al., 2019; Gratz & Gunderson, 2006; Iri et al., 2018; Mahmoudpour et al., 2021; Ruiz et al., 2018). The results of the current study are also inconsistent with the findings of Khakbaz et al. (2014), who stated that ACT led to improvements in emotional regulation strategies in methamphetamine-dependent individuals in an Iranian sample, and Mohammadi et al. (2015) who stated that ACT is effective in men receiving methadone maintenance treatment. The findings of the research

are consistent with the studies of Arch and Craske (2008), Öst (2014), and Powers et al. (2009) which indicate that ACT interventions may not improve emotion regulation in some situations and conditions.

ACT-based interventions can help divorced people become aware of emotions and their negative impact of them. It is suggested that ACT interventions support divorced people to maintain healthy emotions via reappraisal, thus leading to a decrease in the severity of psychological difficulties (Ghorbani Amir et al., 2019). Increasing cognitive emotional regulation skills and reappraisal reduce the intensity of negative emotions and intensify positive emotions resulting in adaptive behaviors for divorced people. ACT aims to use and accept emotions effectively and improve social-emotional adaptation skills. With ACT interventions, individuals realize that when they encounter different emotions, they can tolerate them and cope with negative ones. Individuals learn to accept emotions and develop emotional resilience, instead of suppressing them (Ardeshirzadeh et al., 2022).

In this study, the fact that group intervention based on ACT did not have a significant contribution to the emotion regulation skills of divorced parents, can be attributed to the methodology and individual differences in the participants. The fact that the study lasted eight weeks and was online may have resulted in fewer effects compared to longer-term and face-to-face groups. Almost all studies in the literature consist of face-to-face therapies leading to more therapeutic benefits. Additionally, these unexpected nonsignificant results may be due to the participants' interpretations and skills of emotion regulation, apart from the program design. In this regard, McCracken et al. (2011) and Asanjarani et al. (2018) state that ACT intervention applied to people with low emotional regulation ability has the opposite effect and increases stress instead of reducing unpleasant and unwanted mental experiences. Although the concept of acceptance aims to reduce the need to suppress unwanted thoughts, if it is not perceived correctly may lead to suppression. For example, the instruction to "let go of thoughts" given during both cognitive defusion and acceptance exercises can be misunderstood and used as thought suppression. The emphasis on “letting go” can create an expectation for thoughts to disappear. However, this does not mean that other cognitive defusion methods that do not emphasize letting go of thoughts have this potential (Arch & Craske, 2008). A few points related to studies showing positive effects on emotion regulation differ from this study in terms of participant profile should also be discussed. For example, in the study conducted by Ruiz et al. (2018) which is conducted

with 10 adults with moderate to severe emotional disorders, it was determined that ACT is effective in emotion regulation. In this study, two-session ACT protocol focused on repetitive negative thinking (RNT) was applied. The results showed that most participants experienced an improvement in overall health and a significant reduction in the levels of depression, anxiety, and stress. Although this study demonstrated the effect of the RNT-focused ACT protocol on emotional disorders, RNT-specific protocol or such a protocol specified to emotion regulation was not applied in the current research. Additionally, in the study by Ruiz et al. (2018), participants were people diagnosed with moderate-high emotional disorders. Considering this, the effectiveness of ACT in individuals with moderate emotional difficulties and those without mood disorders is questionable. Similarly, Mahmoudpour et al. (2021) conducted an ACT-based intervention program with 30 divorced women. Women in the experimental group showed a greater increase in emotion regulation skills compared to the control group. In the study, it was stated that approximately half of the divorced women had been divorced for six years or more. Mikaili and Sharifi (2017) declare that emotional regulation is the most difficult in the first three to five years after divorce. Based on this information, the time elapsed after divorce was longer in the study conducted by Mahmoudpour et al. (2021) than in the current study, which is one of the points that should be evaluated when interpreting the results.

4.2.3. Evaluations Regarding the Hypothesis about Depression, Anxiety and Stress

The third hypothesis of the study is "The ACT-based intervention will result in a significant difference between experimental and control groups on Depression, Anxiety and Stress levels." Findings showed that both experimental and control groups started at a similar level of depression, anxiety, and stress before any intervention was implemented. After the 8-week intervention, a significant difference in depression scores was observed between the experimental and control groups. However, no significant difference was found between the depression levels at the follow-up measurement. This indicates that although the intervention has a positive effect on reducing depression levels in the experimental group immediately after the intervention, the initial improvements are not maintained over time. To look at the changes within the experimental group, no statistically significant differences were found in depression scores across the three-time points (pretest, posttest, and follow-up). It means that any observed changes in depression levels are not sustained throughout the measurement

periods. To evaluate the findings related to anxiety, results demonstrated that statistically significant differences in anxiety scores are also found at the posttest and the follow-up measurement. It means that ACT-based group intervention has a significant and lasting impact on reducing anxiety between the experimental and control groups. A statistically significant difference is also found in anxiety scores across the three-time points within the experimental group. This indicates that the intervention led to sustained reductions in anxiety levels over time. Significant differences are found between pretest and follow-up anxiety scores within the experimental group, indicating a meaningful reduction in anxiety levels from the start of the study to the follow-up. However, no significant differences were found between the pretest and posttest, and posttest and follow-up. It means that the most substantial changes occur from pretest to follow-up rather than immediately after the intervention. According to the results, no significant differences were observed in stress scores between the experimental and control groups at the posttest and the follow-up measurement. This suggests that the intervention does not have a significant immediate or long-term reduction in stress levels. Within the experimental group, across the three-time measurement, there were also no statistically significant differences in stress scores. It suggests that ACT-based intervention programs do not lead a consistent or sustained changes.

Findings regarding positive changes in depression and anxiety are consistent with the results of many studies in the literature (Gloster et al., 2020; Gratz & Gunderson, 2006; Koksal, 2023; Rasanen et al., 2016; Ruiz et al., 2018; Shankar, 2014) The findings support other studies that prove the effectiveness of ACT on divorced people to increase depression and anxiety (Mikaili & Sharifi, 2017; Shojaian, 2015). The psychological flexibility components of ACT have many functions in reducing anxiety and depression. Martin and Dahlen (2005) state that self-blame, rumination, catastrophizing, and positive reappraisal are important predictors of depression, stress, and anxiety. In a meta-analysis examining the relationship between depression severity and cognitions, it is stated that the severity of depression increases as the distortion in cognitions rises (McDermott & Ebmeier, 2009). In this respect, people who develop cognitive defusion reduce anxious reactions by keeping distance with thoughts perceived as threatening. Since ACT teaches people to make space for anxious thoughts and feelings rather than struggling with them, it reduces the pressure to control thoughts and emotions. People who improve the ability to focus on the present through mindfulness exercises reduce constant focus on the past or future which reveals the

effect of anxiety. People who decide personal values and increase the contact with them begin to push depressive moods and anxiety into the background by prioritizing committed actions (Harris, 2009). The positive effect of ACT on depression and anxiety levels of parents is associated with its effect on cognitive defusion and acceptance (Byrne, 2020). In this study, it is seen that the participants experienced a significant increase in the two mentioned dimensions of psychological flexibility and decreased levels of depression and anxiety. Making room for emotions such as sadness, disappointment, anger, and mourning that may arise with divorce and keeping a distance from negative thoughts about both the self and the world may have led to this improvement in the participants.

Research on depression and anxiety often appears to compare ACT with CBT or cognitive therapy. One of the leading studies was conducted by Sachs (2005) people diagnosed with generalized anxiety disorder were randomly assigned into three groups: ACT group, emotion-focused therapy, and waitlist group. Within the scope of this study, self-reports and the evaluations of specially trained blind clinicians were taken as the assessment tool. After the intervention, the ACT group was no longer diagnosed with generalized anxiety disorder by clinicians. However, it was observed that there was no difference in terms of the scales scored by the participants. A more recent study investigating the effect of ACT on generalized anxiety disorder was conducted by Avdagic et al. (2014). Male and female participants diagnosed with generalized anxiety disorder were randomly allocated to the ACT and CBT groups. The research results revealed that there was a significant improvement in anxiety in both groups and the improvement continued at the three-month follow-up. Only those in the ACT group showed a more reliable improvement in anxiety (78.9%) compared to the CBT group (47.4%). However, the positive effect disappeared in follow-up measurement, showing a 60% change rate in both groups. One of the strengths of this study was that comorbid problems such as depression were not excluded in the study, which would increase representation. Another comparison of ACT and CBT is conducted with 101 patients with anxiety and depression by Forman et al. (2007). In the study, participants in both groups reported a large and almost equal reduction in anxiety and depression, and improvements in quality of life, functioning, and life satisfaction. While acceptance, experiential avoidance, and awareness of actions mediate the change in the ACT group, the change in CBT is mediated by observing and describing the individual's experience (Forman et al., 2007). Arch et al. (2012) also applied 12 sessions of CBT and ACT therapy to 128 people with one or more anxiety disorders. In this research, CBT and

ACT are found to be equally effective as well. However, in the follow-up measurement, it was observed that individuals who received ACT-based therapy showed more improvement. In another study by Niles et al. (2014), CBT and ACT were applied in two separate groups of 50 adults diagnosed with social anxiety disorder. According to the findings, individuals participating in ACT-based intervention had a higher reduction in depression and anxiety symptoms compared to the other group. Another study was conducted by Gonzalez-Menendez et al. (2014) with 37 women with multiple substance abuse as 90-minute sessions for 16 weeks. As a result of 6, 12, and 18-month follow-ups, both ACT and CBT were seen as effective on substance abstinence. However, in the 18-month follow-up, it is reported that ACT has a greater effect on substance abstinence, avoidance, and especially anxiety. In one of the earlier studies by Zettle and Rains (1989) comparing ACT with cognitive therapy, 31 female participants were divided into two groups. Study results revealed that ACT results in an improvement in the treatment of depression. It was determined that there was also a significant decrease in depression during the follow-up period. Similarly, in a more recent study by Tamannaeifar et al. (2014) comparing ACT with cognitive therapy, it was stated that a significant decrease was observed in the depression level of both groups with no significant difference between the groups. The limitations of both studies are that they were restricted to women with a small sample size.

Although there were significant decreases in stress levels in the experimental group with the effect of the intervention program, this decrease was not found to be statistically significant. These results are inconsistent with the results of several studies (Gloster et al., 2020; Gratz & Gunderson, 2006; Koksal, 2023; Rasanen et al., 2016, Ruiz et al., 2018). However, results are consistent with studies suggesting that ACT interventions are limited or result in a nonsignificant impact on reducing stress (Joekar et al., 2016; Mathew et al., 2021; Prudenzi et al., 2022; Zhang et al., 2022). The conclusion that ACT is not effective enough in reducing stress in some cases can be explained in several ways. Although ACT is a method that does not aim to increase stress and even some of its components facilitate the reduction of stress, an increase in stress can be seen in some conditions. The level of discomfort and stress may initially increase in the ACT interventions as the struggle to maintain values-oriented behavior in the face of challenging situations while living in line with committed actions. The initial increase in stress against challenging situations can also be considered as a process expected to end (Tamannaeifar et al., 2014). On the other hand, ACT encourages individuals to confront and even make space for and contact with

challenging emotions that they tend to avoid. This contact with negative emotions that have been avoided for a long time may firstly increase stress levels. Moreover, regardless of the therapy method, increasing awareness, questioning habits, and reorganizing thoughts and relationships, which are inevitable parts of the therapy process, require effort and time. Despite the exercises, metaphors, or psychoeducation used in group interventions, although a person's awareness sometimes increases, it may take time to change internal processes. The reasons why stress increases despite intervention may be: realizing that running away from emotions, not being able to defuse negative thoughts, not being able to act in line with personal values and realizing the continuation of dysfunctional habits. However, as individuals continue to apply ACT principles in the later process of the intervention, psychological flexibility increases, resistance to change decreases, and stress levels decrease (Eifert & Forsyth, 2005; Harris 2009; Hayes et al., 1999).

4.2.4. Evaluations Regarding the Hypothesis about Parenting

The fourth hypothesis of the study is “The ACT-based intervention will result in a significant difference between the experimental and control group on Positive Parenting skills.” Findings indicated that, for the subscale positive parenting, the experimental group did not show a statistically significant difference compared to the control group. It is observed that the positive parenting scores of the control group gradually decreased in three different measurements, while the positive parenting scores experimental group gradually increased in each measurement. However, the intervention did not result in a statistically significant improvement between groups. To look at positive parenting scores within the experimental group, there was a visible linear increase in the average rank scores from the pretest to the follow-up stage, but this increase was not statistically significant. On the other hand, a similar trend is observed for childcare both between and within group analysis. While the childcare score of the control group decreased over time, that of the experimental group increased. However, the small differences in mean scores between the groups suggest that the intervention did not have a statistically significant impact on the childcare scores. The childcare score of the experimental group on three different measurements also shows a linear increase, despite a decrease in the control group. However, this increase in childcare that emerged with the intervention program was not found to be statistically significant.

These findings are not consistent with studies claims that ACT improves parenting processes by increasing parents' psychological flexibility (Blackledge & Hayes, 2006; Byrne et al., 2020; Coyne & Wilson, 2004; Masuda et al., 2011; Murrel & Hayes, 2006; Scherbarth, 2006; Shiralinia et al., 2017). However, some researchers, such as Gould et al. (2018), have argued that such a positive effect of ACT on parenting exists but it is small. Consistent with the results of the current study, Brown et al. (2014) and Coyne and Wilson (2004) state that ACT intervention alone does not create sufficient change in parenting processes. However, when studies on parents in the literature are examined, ACT interventions aim only to support parental mental health leading to positive changes in measures such as parents' psychological flexibility and well-being. Unlike the current study, most of these studies do not examine any variables on parenting (Blackledge & Hayes, 2006; Fung et al., 2018; Lunsky et al., 2018). On the other hand, many studies suggest that ACT is effective in improving parenting practices, ACT is used in conjunction with other methods such as Applied Behavior Analysis (ABA) (Pennefather et al., 2018), Parent-Child Interaction Therapy (PCIT) (Coyne & Wilson 2004), Stepping Stones Triple P (Brown et al., 2014) and parenting training (Quchani et al., 2021). In these interventions, ACT appears to be a component of the intervention, not the intervention itself. It fails to determine whether and how much ACT alone or other components contributed to the improvements.

The divorce process is challenging in many ways not only for adults but also for children, and this challenge can affect the parenting processes of divorced parents. In the study by Kasuto (2017), which compared the mental health variables of children of divorced families with children of non-divorced families, it is concluded that children of divorced families experience problems such as depression, social introversion, somatic complaints, aggressive behavior, and self-esteem problems more than non-divorced families. Additionally, in the study by Unaldı (2016) about psychiatric disorders in children following divorce, it was found that internalizing disorders such as depression, anxiety, and behavioral disorders are frequently seen in those children. In the same study, risk factors for the psychological well-being of children are determined as the absence of the non-custodial parent in the child's life, and the time after the divorce.

The psychological flexibility and well-being of parents are closely related to the psychological well-being of children. ACT interventions, which help reduce parents' psychological problems such as depression and anxiety, contribute to an increase in

psychological well-being and functionality (Byrne et al., 2020). The fact that ACT interventions reduce parents' psychological distress and improve functionality also benefits parenting practices (Brown et al., 2014; Coyne et al., 2011; Greco et al., 2005). Psychological flexibility in parenting enables parents to accept negative emotions and thoughts that they cannot control about their children, rather than struggling with them. Psychological flexibility in parenting provides consistent and effective parenting (Burke & Moore, 2015). This leads to a reduction in emotional and behavioral problems in children through adaptive parenting approaches (Brassell et al., 2016). ACT-based interventions can positively impact parenting and parent-child relationships in a variety of ways, thanks to psychological flexibility components. First, ACT supports parents to cope more effectively with challenging situations by increasing psychological flexibility. It encourages parents to accept emotions by making room rather than showing experiential avoidance in the face of challenging situations and emotions regarding both them and their children (Hayes et al., 2006). In addition, parents who improve contact with emotions not only advance in expressing personal emotions but also become aware of children's emotions and begin to act with a more sensitive and understanding parenting (Brown et al., 2014). Parents who can recognize and accept children's difficulties can respond more positively to children by remaining calm (Shiralinia et al., 2017). In addition, ACT leads people to defuse verbal rules such as "I cannot tolerate my child's bad behavior" and to create inflexible rules that do not result in experiential avoidance or suppression. ACT interventions offer parents the opportunity to determine values related to parenting, to fulfill committed actions in line with these values, and to experience more meaningful parenting (Coyne & Wilson, 2004).

Despite studies suggesting that ACT is beneficial for children and parents, research in this field is insufficient. Greco and Hayes (2008) state, in the book examining ACT interventions for children and adolescents, that "ACT for children and adolescents has only begun to be discovered recently." Although the popularity of ACT in the field of parenting and children has increased in recent years (Byrne et al., 2020), many scientific studies are still needed to prove its effect (Murrel & Scherbarth, 2006). No studies are found in the literature about the effect of ACT on positive parenting and childcare although there is evidence that improves the effect of ACT on a variety of parenting variables. One of the first studies to examine the parenting practices of ACT is a case study by Coyne and Wilson (2004), in which the intervention was applied to increase the psychological flexibility of the parent and to reduce rule-managed parental behaviors. As a result of the study, positive

effects of ACT interventions are reported on both parent flexibility and parent behavior. Subsequently, Brown et al. (2014) conducted an intervention program consisting of Stepping Stones Triple P: Positive Parenting Program (SSTP) and ACT (Two sessions of ACT and nine sessions of SSTP) with parents of children with acquired brain injury. Participants were randomly assigned to the experimental group to the usual care control condition with families of three-six people each. In addition, 1.5-hour telephone interviews were held with the experimental group, and an SSTP workbook was provided to each family. Study results determined that the intervention is effective in terms of parent psychological distress, parent psychological flexibility, parenting confidence, family functionality, and couple relationships. This positive effect was also observed in the 6-month follow-up measurement. In another study by Byrne et al. (2020), a literature review was conducted with 27 studies in which ACT was used to support parenting skills. In the literature review, many studies support the fact that ACT provides psychological support to parents of children with neurodevelopmental disorders, chronic pain, and physical disabilities. Most of the studies reveal that interventions are effective in the psychological well-being of parents and physical and psychological functionality in children reported by parents. When Byrne et al. (2020) put all these results together, it is concluded that ACT-based parenting interventions or treatment components can be effective on various emotional and behavioral problems seen in children. They stated that ACT may be useful for parents who need to accept unchangeable difficulties and challenging situations related to children. However, since there was no research evaluating parenting processes within the scope of the review. After this review, the effect of ACT intervention on parenting was conducted by Quchani et al. (2021) with 66 divorced women. In this study, an 8-week ACT-based parenting group was compared with the parenting skills training group based on Clark's approach and the control group. Study results also showed that the ACT-based parenting program reduces children's emotional-behavioral problems. However, compared to other groups, the greatest effect in reducing anxiety/depression and attention problems was seen in the children of parents who took the parenting skills training approach. The focus of the ACT-based intervention in this study was parenting. For this reason, the ACT intervention was supported by providing training to parents on parenting skills such as using non-violent techniques and being consistent.

Although the studies mentioned above state that there are improvements in awareness of parents and parenting processes, consistent with the current study, this increase is not

observed in some of them or is not found to be statistically significant (Byrne et al., 2020). For example, Corti et al. (2018) observed a deterioration in awareness skills and no change in cognitive integration skills in parents who participated in the ACT-based parenting program. Blackledge and Hayes (2006) also examined the impact of a two-day ACT workshop for parents of children diagnosed with autism spectrum disorder. Significant reductions were observed in parents' measures of depression and general psychiatric difficulties after treatment, but these changes were relatively small. However, no significant changes were observed in the experiential avoidance level of parents. Researchers argue that ACT may not always have the expected positive effect on parenting, and this may be associated with several factors such as individual differences and readiness (Swain et al., 2015), therapy duration and intensity (Brown et al., 2014), and application differences (Coyne et al., 2011) and measurement tools and evaluation methods (Murrel & Scherbarth, 2006).

The current study, with support from the literature (Brown et al., 2014; Coyne et al., 2011; Greco et al., 2005), assumes that if the psychological flexibility of parents and well-being are improved, psychological flexibility in parenting will increase and parenting practices will also improve. Although there was an increasing trend in the measurements of the experimental group at different measurements and there were visible differences between the scores of the experimental group and the control group, the fact that the effect of the ACT intervention was not statistically significant can be explained in various ways. First, there are fewer studies in the literature showing no positive effects of the ACT intervention because many studies generally emphasize positive effects. Studies with significant positive effects are more likely to be published. For this reason, studies that do not show positive effects on parenting may be less common in the literature. Additionally, the absence of any parenting skills content in the current intervention program may be associated with the lack of a statistically significant increase in positive parenting and childcare scores. Moreover, it may take time and be challenging for parents to respond differently in the parenting processes and relationships with their children. More time and intervention programs that better support parents may be needed for changes in parenting processes. Interventions carried out for longer periods with fewer participants and in which parents are supported in different ways such as phone calls and educational materials may make a difference in terms of change (Brown et al., 2014). For the changes experienced in parenting processes as a result of the intervention program, more time may be needed, and interventions that better

support parents, are carried out for longer periods with fewer participants, and are supported in different ways such as phone calls and educational materials (Brown et al., 2014). On the other hand, some studies associate contradictory results with the complexity and inadequacy of self-report measurements. It is stated that it may be useful to support behavioral changes with observational methods in addition to self-reporting (Corti et al., 2018). In the current study, parenting-related measurements were based solely on self-report. In the current study, possible changes in parenting practice that are not reflected in statistics may be the result of the inadequacy of qualitative data to provide in-depth information about change or lack of observation or other information obtained from the child. Finally, studies showing that ACT has a positive effect on improving parenting mostly case studies or evaluate ACT as part of a combined intervention. Therefore, the need to conduct experimental studies with larger samples with higher statistical power to understand the effects of ACT interventions alone on parenting should not be ignored.

4.3. Strengths

This study has many strengths, both methodologically, regarding the implementation of the program, and measurements. One of the most important positive features of the study in terms of the method is that it is a randomized controlled trial. Random assignment of participants to the experimental and control groups eliminated selection bias and ensured that the groups were similar in terms of dependent variables before the intervention. In this study, no significant difference was detected between the pretest measurements of the experimental and control groups in terms of all variables. This proves the objectivity of the study. Therefore, the difference in posttest and follow-up measurements is attributed solely to the effect of the intervention program. In this respect, the fact that the study was randomized controlled supported its high internal validity. In addition, many inclusion and exclusion criteria for the current study were established in line with the information in the literature. These criteria ensure that the individuals participating in the study were homogeneous and increase the accuracy of the results in the identified population.

When we consider the strengths of the application of the program, it is seen that the online intervention program provides many advantages for the study. The first of these eliminated geographical restrictions and enabled reaching a wider audience of participants. It also increased accessibility by making it easier for participants to easily participate in the

program from wherever they are, without having to physically go anywhere, even in the evening. It provided advantages in terms of time and cost for the participants. To ensure ease of participation, alternative times have been created that they can choose. Three different experimental groups were conducted, and to ensure ease of participation, one was conducted during the day on weekdays, one in the evening on weekdays, and one in the evening on weekends. Particularly people who were working, people who had busy schedules, or people who had limited time due to childcare responsibilities were able to join the group of their choice according to their suitability. Online interventions help ensure anonymity and confidentiality. The rule that "The program should not be recorded by the therapist or the participants in any way or shared on social media", is included in the group rules emphasized in the first session of the program and shared with the participants. Moreover, the group leader indicated that it was sufficient for the people to just write their names without surnames for the application used for the sessions. Hence the protection of privacy was supported by the online group program to create less anxiety and stress.

Another strength of the study, in addition to the online application, is that the intervention program was tested with a pilot study. In the pilot application, changes were made according to the qualitative feedback form of the participants as well as verbal feedback from the participants. For example, while the intervention program was initially 6 weeks, it was increased to 8 weeks in line with most of the participants expressing that they wanted the program to last longer. All exercises, metaphors, and themes in the intervention program implemented in the study were included in the developed protocol. The protocol was followed by the group leader to minimize the difference between experimental groups. The protocol was organized and revised to the opinions of many experts and the final version was implemented after the revisions.

Within the scope of the study, all measurements were taken online before, after, and one month after the intervention program. Online measurement both increased accessibility and ensured that social desirability remained at a minimum. Taking and analyzing one-month follow-up measurements in the study provided the opportunity to evaluate how permanent the effect of the intervention was. posttest results reflect the immediate effect observed after therapy, while follow-up test results reveal the permanence and long-term benefits of the therapy. This methodological approach increased the reliability of the

research and the accuracy of its results, allowing a fair and objective assessment of the effects of the therapy.

4.4. Limitations

Although the study has many strengths, it also has some methodological and practical limitations. First, since the participants were among the people who responded to the social media announcement, the sample was convenience or available sampling. In this respect, when generalizing the study results, it should be taken into consideration that the participants are individuals with high motivation for change and psychological recovery. Therefore, these results are not generalizable to the universe of divorced parents. Another situation that harms the generalizability of the study results is related to participant gender. Although there were no exclusion criteria in this study in terms of parental gender, almost all the participants were female. Although it is stated that gender does not make a significant difference in ACT interventions (Smith, 2017), this fact negatively affected the generalizability of the results.

Although the online implementation of the program is a strength of the study in terms of increasing both participation and accessibility, it also comes up with various limitations. Some participants had problems with internet access while others had poorer digital literacy levels. During the sessions, some of the participants often turned off video chat and participated more passively, even though it was included in the group rules and the group leader warned them frequently. Since most of the participants were at home during the group sessions, they were reluctant to share personal experiences because of worry about others living in the house hearing it. Hence participants were not fully comfortable as well as more easily distracted compared to face-to-face group interventions. Additionally, the lack of non-face-to-face interaction between the therapist and the participants in the online intervention may reduce the effectiveness of the program by harming the therapeutic relationship and group dynamic. In addition, although the program was held online and by the days and hours that the participants stated that they were suitable, two of the three groups implemented late in the evening, especially by considering the sleeping hours of the children. This situation negatively affected the efficiency of the program and the participation of parents.

The findings obtained in this research are limited to personal evaluation of data collection tools. It is assumed that the individuals participating in the research answered the

questions in the measurements sincerely. In the study, qualitative data was collected during the pilot application process during the development of the program. However, only quantitative data was evaluated in measuring the effectiveness of the program. One of the limitations of this study is that the qualitative feedback obtained from the participants was not evaluated. For example, the effect of participants realizing that they had similar or different experiences with other divorced parents and sharing experiences in such a group could not be evaluated within the scope of this study. In addition, although online measurements facilitate the automatic collection and storage of data, they also bring with them many limitations. Nowadays, a substantial number of people complete measurements using phones. This situation increases the risk of random responses and sometimes makes it difficult for people to see all the options in the measurements which is due to their phone settings, increasing the error rate. Additionally, since the scales were filled out online, it was observed that some people gave random answers just to fulfill their responsibilities, especially the control group. However, removing these individuals from the data set would statistically destroy the objectivity of the results, so they were not removed from the data set. Since the control group was measured three times within more than 4 months without any intervention, a significant number of people could not be motivated to complete three different measurement processes. Participants who did not complete at least one measurement, approximately half of all participants who initially enrolled in the program, hat to be removed from the data set. This situation caused the loss of data.

5. CONCLUSION and SUGGESTIONS

Divorce is a psychologically challenging process for both the couple who made this decision and the children. Within the scope of the current study, an 8-week ACT-based online group intervention program was developed to support the mental health of parents after the divorce. To test the effect of the intervention program on different variables, participants were randomly assigned to the experimental and control groups. The findings obtained from the participants before the intervention, immediately after the intervention, and during the one-month follow-up period were analyzed. When the data obtained from the experimental group and the control group were compared, it was observed that there were significant improvements in the experimental group in the areas of psychological flexibility (especially subdomains of acceptance, defusion, self-as-context, and mindfulness), depression, and anxiety. When the scores obtained by the experimental group in three different measurements were compared, the results proved that the intervention program created significant and positive changes in the total psychological flexibility score (especially subdomains of acceptance, defusion, and self-as-context) and depression. These effects were largely maintained during the follow-up period. The intervention program has also notable contribution to a decrease in stress and an increase in positive parenting and childcare. However, this effect was not statistically significant. On the other hand, the intervention does not affect emotion regulation in this population. As a result, while the hypotheses of the study that there would be a significant increase in the psychological flexibility and psychological well-being of individuals participating in the intervention program were confirmed, the hypothesis that the program would significantly improve emotion regulation skills and parenting practices was not confirmed.

In this study, the effect of ACT-based online group intervention on psychological flexibility, emotional regulation, depression, anxiety and stress levels, and parenting practices were examined. In future studies, testing the effectiveness of ACT on other variables (e.g. post-divorce adjustment, loneliness, psychological resilience) in divorced individuals; testing the effects of face-to-face and individual ACT-based group interventions; increasing the generalizability of the program with the results obtained from diverse samples from different demographic groups; increasing the statistical power of the study by increasing the sample size; and comparing the effectiveness of ACT for divorced

parents with other treatments, especially CBT, which is the most compared in the literature are recommended. Moreover, considering that the intervention program does not have a statistically significant effect on parenting practices in the current study, it is recommended that the program content be supported with parenting skills sessions in ACT applications for parents. It is recommended to compare the effect of the combined program of ACT and parenting with other programs implemented to improve parenting or parent-child relationships. In addition, investigating whether interventions targeting both the parent, and the child are more effective than interventions targeting only the parent will help determine which is most efficient in terms of time and cost.

As a result of the experiences gained from the research process, it is thought that some suggestions for future studies about measurements and measurement tools will contribute to the literature. Although there was an upward trend in many sub-dimensions, the lack of statistical significance caused these differences to become invisible. Therefore, any observed improvements because of an intervention should be interpreted with caution, and further research with different methodologies might be needed to confirm and enlighten these findings. Since the aim of ACT, unlike many therapies, is not symptom reduction, in addition to standard measurements the use of valid and reliable measurements regarding both the ACT process will be useful in understanding the mechanisms underlying therapeutic change after the intervention. It is recommended that ACT-specific measures of therapeutic change be included in research. Using mixed methods in subsequent studies helps to determine the effect of the intervention program on different variables that cannot be answered only with quantitative methods. In addition, the use of both scales and open-ended expressions provides the opportunity to look at the research question from a broader perspective. Since studies in which quantitative data are used together with in-depth qualitative data will be more descriptive about why and how therapy is useful or useless in illuminating the individual experiences of the participants, using both together in future studies will be functional. In addition, reporting observations related to the intervention process and sessions are recommended to understand the ACT mechanism that supports therapeutic change. When the impact measurement of the study results is solely reliant on self-report data, it can be susceptible in terms of social desirability and trust. In future studies, therapist observations can also be evaluated to support measurement. Similarly, when evaluating the effect of the intervention program on the change of dependent variables related to parenting, it is recommended to use data obtained from the child, observers, or

teachers instead of only parental reporting. The last issue regarding measurements is that to determine the long-term positive effects of the ACT therapy program to be applied, follow-up studies can be carried out at intervals such as three months, six months, and one year, and the permanence of the program can be tested.

It would be useful to offer a few suggestions to researchers who will investigate the effects of intervention programs to be developed for divorced parents. Traditional gender roles may cause fathers to take less role and responsibility in childcare and parenting. It is still seen that men in general and fathers in particular participate very little in psychological intervention programs. In this context, specially designed male-focused programs can be created to increase fathers' participation and make them feel more comfortable. Men, and especially fathers, can be informed that such programs aim to strengthen their parenting roles, and their participation can be increased by informing them about the positive effects of participation in these programs for mental health. Secondly, to prevent the loss of the effects of the intervention program, it is recommended to hold reminder sessions after a certain period following the completion of group sessions. In addition, the current program has been implemented online to avoid difficulties in terms of transportation and the possibility that a significant portion of divorced people are working. It is also recommended that people who will implement group intervention provide information about the group by giving an individual introductory session to the participants before the group sessions, answering the person's questions if any, and support to relieve concerns about the program and nurture the therapeutic relationship. Finally, during the implementation process of the program, it was concluded that individuals were better able to use audio and visual materials prepared on the subjects studied in their daily lives. In future studies, it is recommended that an audio recording file containing informative booklets and exercises on the subject be prepared and shared with the participants so that individuals can benefit from the program even after it is completed.

6. REFERENCES

Acri, M. C., & Hoagwood, K. E. (2015). Addressing parental mental health within interventions for children: A review. *Research on Social Work Practice*, 25, 578–586. https://doi.org/10.1177/1049731514546027

Aktaş, Ö. (2011). Boşanma Nedenleri ve Boşanma Sonrasında Karşılaşılan Güçlükler. Yayımlanmamış Doktora Tezi, Eğitim Bilimleri Enstitüsü, Dokuz Eylül Üniversitesi. İzmir.

Aktürk, K (2023). Boşanmiş Kadınların Karşılaştıkları Güçlüklerin Psikososyal Bağlamda Değerlendirilmesi. Yüksek Lisans Tezi. İstanbul Aydın Üniversitesi. İstanbul.

Akoğlu, Ö. A., Küçükkaragöz, H. (2018). Boşanma Nedenleri ve Boşanma Sonrasında Karşılaşılan Güçlüklere İlişkin Bir Araştırma: İzmir İli Örneği, Toplum ve Sosyal Hizmet. 29(1), 153-172.

Amato, P. R. (2000). The consequences of divorce for adults and children. *Journal of Marriage and Family*, 62(4), 1269-1287.

Arbuthnot, J., & Gordon, D. A. (1996). Does mandatory divorce education for parents work? A six-month outcome evaluation. *Family Court Review*, 34(1), 60-81. https://doi.org/10.1111/j.174-1617.1996.tb00400.x

Arch, J. J., Eifert, G. H., Davies, C., Vilardaga, J. C. P., Rose, R. D., & Craske, M. G. (2012). Randomized clinical trial of cognitive behavioral therapy (CBT) versus acceptance and commitment therapy (ACT) for mixed anxiety disorders. *Journal of Consulting and Clinical Psychology*, 80(5), 750.

Ardeshirzadeh, M., Bakhtiarpour, S., Homaei, R., & Eftekhar Saadi, Z. (2022). The Effectiveness of Compassion-Focused Therapy and Acceptance and Commitment Therapy on Post-Divorce Adjustment in Divorced Women Referred to Counseling Center in Ahvaz. *Journal of Health Sciences & Surveillance System*, 10(1), 36-43.

Asanjarani, F., Jazayeri, R., Fatehizade, M., Etemadi, O., De Mol, J., The effectiveness of Fisher's rebuilding group intervention on divorce adjustment and general health of Iranian divorced women. *Journal of Divorce & Remarriage*. 2018; 59(2):108-22. [DOI:10.1080/10502556.2017.13 75334]

Avdagic, E., Morrissey, S., & Boschen, M. (2014). A randomised controlled trial of acceptance and commitment therapy and cognitive-behaviour therapy for generalised anxiety disorder. *Behaviour Change*, 31, 110-130. https://doi.org/10.1017/bec.2014.5

Azimifar, S. H., Jazayeri, R., Fatehizade, M., & Abedi, A. (2018). The comparing the effects of parent management training and acceptance and commitment-based parenting training on mother-child relationship among mothers who have children with externalizing behavior problems. *Journal of Family Counseling & Psychotherapy*, 7(2), 99–122. (Persian).

Bach, P. A., & Moran, D. J. (2008). *ACT in Practice: Case Conceptualization in Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Publications.

Bacon, T., Farhall, J., & Fossey, E. (2014). The active therapeutic processes of acceptance and commitment therapy for persistent symptoms of psychosis: Clients' perspectives. *Behavioural and Cognitive Psychotherapy*, 21, 1-19.

Barnett, M. A., de Baca, T. C., Jordan, A., Tilley, E., & Ellis, B. J. (2015). Associations among child perceptions of parenting support, maternal parenting efficacy, and maternal depressive symptoms. *In Child & Youth Care Forum* (Vol. 44, No. 1, pp. 17-32). Springer US.

Baysal, N., & Dağlı, A. (2016). Adaptation of the Satisfaction with Life Scale into Turkish: Validity and reliability study. *Electronic Journal of Social Sciences*, 15(59), 1250-1262.

Beck, A. T. (1979). *Cognitive therapy of depression*. Guilford press.

Beck, A. T., & Emery, G. (1985). *Anxiety Disorders and Phobias: A Cognitive Perspective*. New York: Basic Books.

Belsky, J. (1984). The determinants of parenting: A process model. *Child Development*, 83-96.

Blackledge, J. T. (2003). An Introduction to Relational Frame Theory: Basics and Applications. *The Behavior Analyst Today*, 3(4), 421-433.

Blackledge, J. T., & Hayes, S. C. (2006). Using Acceptance and Commitment Training in the Support of Parents of Children Diagnosed with Autism. *Child and Family Behavior Therapy*, 28(1), 1-18. https://doi.org/10.1300/J019v28n01_01

Blatt, S. J. (1974). Levels of object representation in anaclitic and introjective depression. *Psychoanalytic Study of the Child*, 29, 107-157.

Bloy, S. (2013). Acceptance and commitment therapy for individuals with psychosis: A grounded theory analysis. Doctorate Thesis. Retrieved from: https://create.canterbury.ac.uk/12449/1/Sally_Bloy_MRP_2013.pdf

Bohlmeijer, E. T., Fledderus, M., Rokx, T. A. J. J., & Pieterse, M. E. (2011). Efficacy of an early intervention based on Acceptance and Commitment Therapy for adults with depressive symptomatology: Evaluation in a randomized controlled trial. *Behaviour Research and Therapy*, 49(1), 62-67.

Bohlmeijer, E. T., Lamers, S. M. A., & Fledderus, M. (2015). Flourishing in people with depressive symptomatology increases with Acceptance and Commitment Therapy: Post-hoc analyses of a randomized controlled trial. *Behaviour Research and Therapy*, 65, 101-106.

Bolderston, H. (2013). Acceptance and Commitment Therapy: Cognitive Fusion and Personality Functioning. Doctoral Dissertation. University of Southampton, Faculty of Social and Human Sciences, School of Psychology.

Boone, M., & Manning, J. (2012). A pilot study of an acceptance and commitment therapy group for anxiety and depression in a college counseling center. Manuscript in preparation.

Brassell, A. A., Rosenberg, E., Parent, J., Rough, J. N., Fondacaro, K., & Seehuus, M. (2016). Parent's psychological flexibility: Associations with parenting and child psychosocial well-being. *Journal of Contextual Behavioral Science*, 5, 111–120. https://doi.org/10.1016/j.jcbs.2016. 03.001

Brassington, L., Ferreira, N. B., Yates, S., Fearn, J., Lanza, P., Kemp, K., & Gillanders, D. (2016). Better living with illness: A transdiagnostic Acceptance and Commitment Therapy group intervention for chronic physical illness. *Journal of Contextual Behavioral Science*, 4.

Brinkborg, H., Michanek, J., Hesser, H., & Berglund, G. (2011). Acceptance and Commitment Therapy for the treatment of stress among social workers: A randomized controlled trial. *Behaviour Research and Therapy*, 49(6), 389-398.

Broadhead, W. E., Blazer, D. G., George, L. K., & Tse, C. K. (1990). Depression, disability days, and days lost from work in a prospective epidemiologic survey. *The Journal of the American Medical Association*, 264(19), 2524-2528. doi:10.1001/jama.264.19.2524

Brown, F. L., Whittingham, K., Boyd, R. N., McKinlay, L., & Sofronoff, K. (2014). Does stepping stones triple P plus acceptance and commitment therapy improve parent, couple, and family outcomes following acquired brain injury?. *Journal of Child and Family Studies*, 23(2), 299-310.

Burckhardt, R., Manicavasagar, V., Batterham, P. J., & Pavlovic, D. H. (2016). A randomized controlled trial of Strong Minds: A school-based mental health program combining Acceptance and Commitment Therapy and positive psychology. *Journal of School Psychology*, 57, 41-52.

Burhan, H. S., & Şafak, Y. (2019). Relationship of models of consistency and psychological flexibility with persecutory delusions. *Journal of Cognitive Behavioral Psychotherapy and Research*, 8(3), 179-189.

Byrne, G., Ghráda, Á. N., O'Mahony, T., & Brennan, E. (2021). A systematic review of the use of acceptance and commitment therapy in supporting parents. *Psychology and Psychotherapy: Theory, Research and Practice*, 94, 378-407.

Caimano, S., Malkin, A., Monroy, P., Horoky, D., & Kum, J. J. (2024). A Scoping Review of Acceptance and Commitment Therapy in Higher Education. The Psychological Record, 74(1), 101-132.

Cansız, A., Nalbant, A., & Yavuz, K. A. (2020). Investigation of psychological flexibility in patients with schizophrenia. *Journal of Cognitive Behavioral Psychotherapy and Research*, 9(2), 82-93.

Casselman, R. B., & Pemberton, J. R. (2015). ACT-based parenting group for veterans with PTSD: Development and preliminary outcomes. *The American Journal of Family Therapy*, 43(1), 57-66. https://doi.org/10.1080/01926187.2014.939003

Cherlin, A. J., Chase-Lansdale, P. L., & McRae, C. (1998). Effects of parental divorce on mental health throughout the life course. *American Sociological Review*, 239-249.

Cicek-Gümüş, E. (2020). The effect of Acceptance and Commitment Therapy-based interventions on psychological resilience, depression, anxiety, stress levels, and caregiving burden in parents of children with special needs. Doctoral Dissertation.

Ciarrochi, J., & Bailey, A. (2008). A CBT-practitioner's guide to ACT: How to bridge the gap between cognitive behavioral therapy and acceptance and commitment therapy. Oakland: New Harbinger Publications.

Ciarrochi, J., Bilich, L., & Godsell, C. (2010). Psychological flexibility as a mechanism of change in acceptance and commitment therapy. In R. A. Baer (Ed.), Assessing mindfulness and acceptance processes in clients: Illuminating the theory and practice of change (pp. 51–75). Context Press/New Harbinger Publications.

Cioffi, D., & Holloway, J. (1993). Delayed costs of suppressed pain. *Journal of Personality and Social Psychology*, 64, 274-282.

Clark, M. M., & Waller, T. (Eds.). (2007). *Early childhood education and care: policy and practice*. Sage.

Cohen, J. (1988). Statistical power analysis for the behavioral sciences. Routledge.

Coppen, A., & Metcalfe, M. (1965). Effect of a depressive illness on M. P. I. scores. *The British Journal of Psychiatry*, 111(472), 236-239. doi:10.1192/bjp.111.472.236

Corti, C., Pergolizzi, F., Vanzin, L., Cargasacchi, G., Villa, L., Pozzi, M., & Molteni, M. (2018). Acceptance and commitment therapy-oriented parent-training for parents of children with autism. *Journal of Child and Family Studies*, 27, 2887–2900. https://doi.org/10.1007/s10826- 018-1123-3

Coyne, L. W., McHugh, L., & Martinez, E. R. (2011). Acceptance and commitment therapy (ACT): Advances and applications with children, adolescents, and families. *Child and Adolescent Psychiatric Clinics*, 20, 379–399. https://doi.org/10.1016/j.chc.2011.01.010

Coyne, L. W., McHugh, L., & Martinez, E. R. (2011). Acceptance and Commitment Therapy (ACT) for parent-child relationships. *The Family Journal*, 19(2), 189-198.

Coyne, L. W., & Wilson, K. G. (2004). The role of cognitive fusion in impaired parenting: An RFT analysis. *Journal of Contextual Behavioral Science*, 3(1), 24-30.

Craske, M. G., Niles, A. N., Burklund, L. J., Wolitzky-Taylor, K. B., Vilardaga, J. C. P., Arch, J. J., Saxbe, D. E. & Lieberman, M. D. (2014). Randomized controlled trial of cognitive behavioral therapy and acceptance and commitment therapy for social phobia: Outcomes and moderators. *Journal of Consulting and Clinical Psychology*, 82(6), 1034.

Crosby, J. M., & Twohig, M. P. (2016). Acceptance and Commitment Therapy for problematic internet pornography use: A randomized trial. *Behavior Therapy*, 47(3), 355-366.

Cutuli, D. (2014). Cognitive reappraisal and expressive suppression strategies role in the emotion regulation: An overview on their modulatory effects and neural correlates [Review]. *Frontiers in Systems Neuroscience*, 8. https://doi.org/10.3389/fnsys.2014.00175

Çekiç, A., Türk, F., Buğa, A., & Hamamcı, Z. (2018). Adaptation of the Alabama Parenting Questionnaire into Turkish: Validity and reliability study. *Electronic Journal of Social Sciences*, 17(66), 728-743.

Çimen, M. B. (2023). Boşanmış Kadınlarda Boşanmaya Uyum, Sosyal Destek Algısı ve Yalnızlık Algısı Arasındaki İlişkiler. Yüksek Lisans Tezi, İstanbul Nişantaşı Üniversitesi. İstanbul.

Dahl, J., & Lundgren, T. (2006). *Living Beyond Your Pain*. Oakland, CA: New Harbinger Publications.

Daryanani, I., Hamilton, J. L., Abramson, L. Y., & Alloy, L. B. (2016). Single mother parenting and adolescent psychopathology. *Journal of Abnormal Child Psychology*, 44(7), 1411-1423.

Davis, K. (1988). *Human Behavior in Business*. Faculty of Business Publishing.

Davies, C.D., Niles, A.N., Pittig, A., Arch, J.J., Craske, M.G. Physiological and behavioral indices of emotion dysregulation as predictors of outcome from cognitive behavioral therapy and acceptance and commitment therapy for anxiety. *Journal of Behavior Therapy and Experimental Psychiatry*. 2015; 46: 35-43. https://doi: 10.1016/j.jbtep.2014.08.002

De Graaf, I., Speetjens, P., Smit, F., De Wolff, M., & Tavecchio, L. (2008). Effectiveness of the Triple P Positive Parenting Program on parenting: A meta-analysis. *Family Relations,* 57(5), 553-566.

DeGarmo, D. S., & Jones, J. A. (2019). Fathering through change (FTC) intervention for single fathers: Preventing coercive parenting and child problem behaviors. *Development and Psychopathology*, 31(5), 1801-1811.

Demirci-Seyrek, Ö. (2017). The effect of an Acceptance and Commitment Therapy-oriented psychoeducation program on the meaning of life level in university students. Doctoral Dissertation.

Demirkan, S., Ersöz, A., Şen, R., Ertekin, E., Sezgin, Ö., Turgut, A., & Şehitoğlu, N. (2009). Boşanma Nedenleri Araştırması. T.C. Başbakanlık Aile ve Sosyal Araştırmalar Genel Müdürlüğü. Ankara.

Dewhurst, E., Novakova, B., & Reuber, M. (2015). A prospective service evaluation of Acceptance and Commitment Therapy with refractory epilepsy. *Epilepsy and Behaviour*, 46, 234–241.

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, 49(1), 71–75.

Durrant, J. E., Plateau, D. P., Ateah, C., Stweart-Tufescu, A., Jones, A., Ly, G., Barker, L., Holden, G. W., Kearley, C., MacAulay, J., Peters, R. D., & Tapanya, S. (2014). Preventing punitive violence: Preliminary data on the Positive Discipline in Everyday Parenting (PDEP) program. *Canadian Journal of Community Mental Health*, 33(2), 109-125.

Eifert, G. H., & Forsyth, J. P. (2005). *Acceptance and Commitment Therapy for Anxiety Disorders*. Oakland, CA: New Harbinger Publications.

Eilenberg, T., Kronstrand, L., Fink, P., & Frostholm, L. (2014). Acceptance and Commitment Group Therapy for health anxiety: Results from a pilot study. *Journal of Anxiety Disorders*, 27(5), 461-468.

Eira Nunes, C., De Roten, Y., El Ghaziri, N., Favez, N., & Darwiche, J. (2021). Co-parenting programs: A systematic review and meta-analysis. *Family Relations*, 70(3), 759-776.

Emery, R. E. (2016). *Two homes, one childhood: A parenting plan to last a lifetime*. Penguin.

Evans, T., Whittingham, K., & Boyd, R. (2012). What helps the mother of a preterm infant become securely attached, responsive and well-adjusted?. Infant Behavior & Development, 35, 1–11. https://doi.org/10.1016/j.infbeh.2011.10.002

Fabricius, W. V., & Luecken, L. J. (2007). Postdivorce living arrangements, parent conflict, and long-term physical health correlates for children of divorce. *Journal of Family Psychology*, 21(2), 195.

Fledderus, M., Bohlmeijer, E. T., Fox, J. P., Schreurs, K. M. G., & Spinhoven, P. (2013). The role of psychological flexibility in a self-help Acceptance and Commitment Therapy intervention for psychological distress in a randomized controlled trial. *Behaviour Research and Therapy*, 51(3), 142-151.

Flaxman, P. E., Blackledge, J. T., & Bond, F. W. (2011). *Acceptance and Commitment Therapy: Distinctive Features*. Routledge.

Folke, F., Parling, T., & Lennart, M. (2012). Acceptance and commitment therapy for depression: A preliminary randomized clinical trial for unemployed on long-term sick leave. *Cognitive and Behavioral Practice*, 19, 583-594.

Forgatch, M. S., & DeGarmo, D. S. (1999). Parenting through change: An effective prevention program for single mothers. *Journal of Consulting and Clinical Psychology*, 67(5), 711.

Forman, E. M., & Butryn, M. L. (2015). A new look at the science of weight control: How acceptance and commitment strategies can address the challenge of self-regulation. *Appetite*, 84(1), 171-180.

Frick, P. J. (1991). The Alabama Parenting Questionnaire. Unpublished Rating Scale, University of Alabama.

Furstenberg Jr, F. F., & Nord, C. W. (1985). Parenting apart: Patterns of childrearing after marital disruption. *Journal of Marriage and the Family*, 893-904.

Gaynor, K., & Gordon, O. (2019). Cognitive Behavioral Therapy for mild-to-moderate transdiagnostic emotional dysregulation. *Journal of Contemporary Psychotherapy*, 49(2), 71-77.

Genctan, E. (1981). *Psychoanalysis and Aftermath*. Istanbul.

Ghochani, M., Saffarian Toosi, M. R., & Khoynezhad, G. R. (2020). A comparison between the effectiveness of the combined couple therapy and emotionally focused therapy for couples on the improvement of intimacy and PTSD. *Learning and Motivation*, 71, Article 101637. https://doi.org/10.1016/j.lmot.2020.101637

Glazer, H. R., Clark, M. D., Thomas, R., & Haxton, H. (2010). Parenting after the death of spouse. *American Journal of Hospice and Palliative Medicine*, 27(8), 532-536.

Gloster, A. T., Walder, N., Levin, M. E., Twohig, M. P., & Karekla, M. (2020). The empirical status of acceptance and commitment therapy: A review of meta-analyses. *Journal Of Contextual Behavioral Science*, 18, 181-192.

González-Menéndez, A., Fernández, P., Rodríguez, F., & Villagrá, P. (2014). Long-term outcomes of Acceptance and Commitment Therapy in drug-dependent female inmates: A randomized controlled trial. *International Journal of Clinical and Health Psychology*, 14(1), 18-27.

Gordon, T. (2000). *Parent Effectiveness Training: The Proven Program for Raising Responsible Children*. New York: Three Rivers Press.

Gordon, T. (2008). *Parent Effectiveness Training: The Proven Program for Raising Responsible Children*. Harmony.

Gordon, T., Borushok, J., & Polk, K.L. (2017). *The ACT Approach: A Comprehensive Guide for Acceptance and Commitment Therapy*. PESI Publishing & Media.

Gould, E. R., Tarbox, J., & Coyne, L. (2018). Evaluating the effects of acceptance and commitment training on the overt behavior of parents of children with autism. *Journal of Contextual Behavioral Science*, 7, 81–88. https://doi.org/10.1016/j.jcbs.2017.06.003

Graham, C. D., Gouick, J., Krahé, C., & Gillanders, D. (2016). A systematic review of the use of Acceptance and Commitment Therapy (ACT) in chronic disease and long-term conditions. *Clinical Psychology Review*, 46, 46-58.

Gratz, K. L., & Gunderson, J. G. (2006). Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with borderline personality disorder. *Behavior Therapy*, 37(1), 25-35.

Greco, L. A., Heffner, M., Poe, S., Ritchie, S., Polak, M., & Lynch, S. K. (2005). Maternal adjustment following preterm birth: Contributions of experiential avoidance. *Behavior Therapy*, 36(2), 177-184.

Greco, L., & Hayes, S. (2008). Acceptance and Mindfulness Treatments for Children and Adolescents: A Practitioner's Guide. Oakland, CA: New Harbinger Publications.

Gross, J. J., & John, O. P. (2003). Individual differences in two emotion regulation processes: implications for affect, relationships, and well-being. *Journal of Personality and Social Psychology*, 85(2), 348.

Gross, J. J., & Barrett, L. F. (2011). Emotion generation and emotion regulation: One or two depends on your point of view. *Emotion Review*, 3(1), 8-16.

Gross, J. J., & Thompson, R. A. (2007). Emotion Regulation: Conceptual Foundations. In J. J. Gross (Ed.), *Handbook of Emotion Regulation* (pp. 3-24). New York, NY, US: Guilford Press.

Gross, J. J. (1998). The emerging field of emotion regulation: An integrative review. *Review of General Psychology*, 2(3), 271-299.

Gross, J. J. (2014). Emotion regulation: Conceptual and Empirical Foundations. In J. J. Gross (Ed.), *Handbook of Emotion Regulation* (2nd ed., pp. 3-20). Guilford Press.

Gülay, S., & Uysal, B. (2020). The effectiveness of Acceptance and Commitment Therapy (ACT) on the treatment of symptoms related to traumatic experience: A systematic review. 2nd Cognitive Behavioral Psychotherapies Congress, Online Congress.

Gümüş, E. Ç. (2020). Özel gereksinimli çocuğu olan ebeveynlere uygulanan kabul ve kararlılık terapisi temelli girişimlerin psikolojik sağlamlık depresyon anksiyete stres düzeylerine ve bakım yüküne etkisi. Doktora tezi. Akdeniz Üniversitesi, Sağlık Bilimleri Enstitüsü, Hemşirelik Anabilim Dalı. Antalya.

Habibollahi, A., & Soltanizadeh, M. (2016). Efficacy of Acceptance and Commitment Therapy on body dissatisfaction and fear of negative evaluation in girl adolescents with body dysmorphic disorder. *Mazandaran University of Medical Sciences*, 26(134), 278-290.

Hald, G. M., Ciprić, A., Øverup, C. S., Štulhofer, A., Lange, T., Sander, S., ... & Strizzi, J. M. (2020). Randomized controlled trial study of the effects of an online divorce platform on anxiety, depression, and somatization. *Journal of Family Psychology*, 34(6), 740-751. https://doi:10.1037/fam0000635

Halisdemir, D. (2020). The impact of the Divorce Adjustment Program on divorce adjustment, psychological resilience, and family life satisfaction of mothers with custody and their children. Unpublished Doctoral Dissertation, Ankara University, Institute of Educational Sciences.

Hamid, N. Bashlandeh, K. Eidi, M. (1390). Investigate the relationship between cognitive behavior therapy on depression of divorced women. *Journal of Consulting and Family Psychotherapy*, Volume 1, Issue 1, pp. 54-65.

Hann, K. E. J., & McCracken, L. M. (2014). A systematic review of randomized controlled trials of Acceptance and Commitment Therapy for adults with chronic pain: Outcome domains, design quality, and efficacy. *Journal of Contextual Behavioral Science*, 3(4), 217-227.

Harris, R. (2009). *ACT Made Simple: An Easy-To-Read Primer on Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Publications.

Hart, C. H., Nelson, D. A., Robinson, C. C., Olsen, S. F., & McNeilly-Choque, M. K. (1998). Overt and relational aggression in Russian nursery-school-age children: Parenting style and marital linkages. *Developmental Psychology*, 34(4), 687.

Hawley, L. L., Ho, M.-H. R., Zuroff, D. C., & Blatt, S. J. (2006). The relationship of perfectionism, depression, and therapeutic alliance during treatment for depression: Latent difference score analysis. *Journal of Consulting and Clinical Psychology*, 74(5), 930-942. https://doi.org/10.1037/0022-006X.74.5.930

Hayes, S. C. (1993). Analytic goals and the varieties of scientific contextualism. In S. C. Hayes, D. Barnes-Holmes, & B. Roche (Eds.), *Relational Frame Theory: A Post-Skinnerian Account of Human Language and Cognition* (pp. 153-190). New York: Plenum.

Hayes, S. C. (2004). Acceptance and Commitment Therapy, Relational Frame Theory and the third wave of behavioral and cognitive therapies. *Behavior Therapy*, 35, 639-665.

Hayes, S. C., Bissett, R., Korn, Z., Zettle, R. D., Rosenfarb, I., Cooper, L., & Grundt, A. (1999). The impact of acceptance versus control rationales on pain tolerance. *The Psychological Record*, 49, 33-47.

Hayes, S. C., & Hayes, L. J. (1989). The verbal action of the listener as a basis for rule-governance. In S. C. Hayes (Ed.), *Rule-Governed Behavior: Cognition, Contingencies, and Instructional Control* (pp. 153-190). New York: Plenum.

Hayes, S. C., Levin, M. E., Plumb-Vilardaga, J., Villatte, J. L., & Pistorello, J. (2013). Acceptance and Commitment Therapy and contextual behavioral science: Examining the progress of a distinctive model of behavioral and cognitive therapy. *Behavior Therapy*, 44(2), 180-198. https://doi.org/10.1016/j.beth.2009.08.002

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy*, 44, 1-28.

Hayes, S. C., Smith, S., & Wilson, K. G. (2005). Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy. Oakland, CA: New Harbinger Publications.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change. New York: Guilford Press.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2011). Acceptance And Commitment Therapy: The Process And Practice Of Mindful Change. New York: Guilford press.

Heffner, M., & Eifert, G. H. (2004). The Anorexia Workbook: How to Accept Yourself, Heal Your Suffering and Reclaim Your Life. Oakland, CA: New Harbinger Publications.

Henry, J. D., & Crawford, J. R. (2005). The short-form version of the Depression Anxiety Stress Scales (DASS-21): Construct validity and normative data in a large non-clinical sample. *British Journal of Clinical Psychology*, 44(2), 227-239.

Hermann, B. A., Meyer, E. C., Schnurr, P. P., Batten, S. V., & Walser, R.D. (2016). Acceptance and Commitment Therapy for co-occurring PTSD and substance use: A manual development study. *Journal of Contextual Behavioral Science*. Advance online publication.

Iri, H., Makvandi, B., Bakhtiarpour, S., & Hafezi, F. (2019). Comparison of the effectiveness of Acceptance and Commitment Therapy and Dialectical Behavioral Therapy on health anxiety, psychosocial adjustment, and cognitive emotion regulation of divorced women. *Medical Journal of Mashhad University of Medical Sciences*, 61(1), 79-88.

Jansen, J. E., & Morris, E. M. J. (2015). Acceptance and Commitment Therapy for posttraumatic stress disorder in early psychosis: A case series. *Cognitive and Behavioral Practice*. Available online at www.googlescholar.com.

Joekar, S., Farid, A. A., Birashk, B., Gharraee, B., & Mohammadian, M. (2016). Effectiveness of acceptance and commitment therapy in the support of parents of children with high-functioning autism. *International Journal of Humanities and Cultural Studies*, 2, 2763–2772.

Joshanpoush, S., Fazilatpour, M., & Rahmati, A. (2017). The effectiveness of parent-child relationship training based on ACT on the parent-adolescent conflict of mothers with epileptic child. *Journal of Cognitive and Behavioral Science (CBS)*, 7, 39–50. (Persian).

Kasuto, M. (2017). Boşanmış ailelerin çocuklarının boşanmamış ailelerin çocuklarına göre öz saygı ve ruh sağlığı değişkenlerinin incelenmesi (Master's thesis). Işık Üniversitesi, İstanbul.

Katajavuori, N., Vehkalahti, K., & Asikainen, H. (2023). Promoting university students' well-being and studying with an acceptance and commitment therapy (ACT)-based intervention. *Current Psychology*, 42(6), 4900-4912.

Kaya-Akdemir, M. (2018). The effect of an Acceptance and Commitment Therapy-oriented psychoeducation program on coping efficacy. Doctoral Dissertation.

Kelly, J. B. (2007). Children's adjustment in conflicted marriage and divorce: A decade review of research. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46(8), 970-987.

Khakbaz, H., Farhoudian, A., Azkhosh, M., Dolatshahi, B., Karami, H., & Massah, O. (2014). The effectiveness of group Acceptance and Commitment Therapy on emotional regulation in Methamphetamine-dependent individuals undergoing rehabilitation. *International Journal of High Risk Behaviors and Addiction*, 5, e28329.

Kingston, J. (2008). Acceptance and Commitment Therapy (ACT) process and outcome: A systematic evaluation of ACT for treatment-resistant patients. Doctoral Dissertation. University of Southampton, School of Psychology.

Kotchick, B. A., Dorsey, S., & Heller, L. (2005). Predictors of parenting among African American single mothers: Personal and contextual factors. *Journal of Marriage and Family*, 67(2), 448-460.

Lazarus, R. S. (1991). Cognition and motivation in emotion. *American Psychologist*, 46(4), 352.

Lazarus, R. S., & Folkman, S. (1984). *Stress, Appraisal, and Coping*. New York: Springer Publishing Company, John Wiley & Sons, Inc.

Levin, M., & Hayes, S. C. (2009). ACT, RFT, and Contextual Behavioral Science. *Acceptance and Commitment Therapy: Contemporary Theory Research and Practice*. In J. T. Blackledge, J. Ciarrochi, & F. P. Deane (Eds.), pp. 1-40. Australia: Australian Academic Press.

Luciano, J. V., Guallar, J. A., Aguado, J., Hoyo, Y. L., Olivan, B., Magallón, R., Alda, M., Blanco, A. S., Gili, M., & Campayo, J. G. (2014). Effectiveness of group Acceptance and Commitment Therapy for fibromyalgia: A 6-month randomized controlled trial. *Pain*, 155(4), 693-702.

Lunsky, Y., Fung, K., Lake, J., Steel, L., & Bryce, K. (2018). Evaluation of acceptance and commitment therapy (ACT) for mothers of children and youth with autism spectrum disorder. *Mindfulness*, 9, 1110–1116. https://doi.org/10.1007/s12671-017-0846-3

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2007). *Learning ACT: An Acceptance and Commitment Therapy Skills-Training Manual for Therapists*. Oakland, CA: New Harbinger & Reno, NV: Context Press.

Mahn, D., & Rayesh, N., & Ghanbarian, E., & Rezaee, M. (2021). Effectiveness of acceptance and commitment therapy (ACT) on emotional regulation and loneliness of divorced women in Iran. *Journal of Marital and Family Therapy*, 47, 831–842. https://doi.org/10.1111/jmft.12492

Marwaha, S., Parsons, N., Flanagan, S., & Broome, M. (2013). The prevalence and clinical associations of mood instability in adults living in England: Results from the Adult Psychiatric Morbidity Survey 2007. *Psychiatry Research*, 205(3), 262-268. https://doi.org/10.1016/j.psychres.2012.09.036

Martin, R. C., & Dahlen, E. R. (2005). Cognitive emotion regulation in the prediction of depression, anxiety, stress, and anger. Personality and Individual Differences, 39(7), 1249-1260. https://doi: 10.1016/j.paid.2005.06.004

Masuda, A., Hayes, S. C., Sackett, C. F., & Twohig, M. P. (2004). Cognitive Defusion and Self-relevant Negative Thoughts: Examining the Impact of a 90 Year Old Technique. *Behaviour Research and Therapy*, 42(4), 477-485.

Mathew, A., Doorenbos, A. Z., Jang, M. K., & Hershberger, P. E. (2021). Acceptance and commitment therapy in adult cancer survivors: a systematic review and conceptual model. *Journal of Cancer Survivorship*, 15, 427-451.

McCracken, L. M., & Eccleston, C. (2003). Coping or acceptance: What to do about chronic pain? *Pain*, 105, 197-204.

McCracken, L. M., Gutiérrez-Martínez, O. (2011). Processes of change in psy- chological flexibility in an interdisciplinary group-based treatment for chronic pain based on Acceptance and Commitment Therapy. *Behaviour Research and Therapy*. 49(4):267-74. https://doi.org/10.1016/j.brat.2011.02.004

McDermott, L. M., & Ebmeier, K. P. (2009). A meta-analysis of depression severity and cognitive function. *Journal of Affective Disorders*, 119(1-3), 1-8. . https://doi:10.1016/j.jad.2009.04.022

McRae, K., & Gross, J. J. (2020). Emotion regulation. *Emotion*, 20(1), 1.

Meuret, A. E., Twohig, M. P., Rosenfield, D., Hayes, S. C., & Craske, M. G. (2012). Brief Acceptance and Commitment Therapy and exposure for panic disorder: A pilot study. *Cognitive and Behavioral Practice*, 19(4), 606-618.

Mikaili, N., & Sharifi, V. (2017). Effectiveness of Acceptance and Commitment Therapy on depression, anxiety, and flexibility of divorced young women. *Journal of Social Sciences and Humanities Research*, 5(01), 64-68.

Miller, J. A. (2002). *The Childhood Depression Sourcebook*. Anchor. McGraw-Hill.

Mohammadi, L., Salehzadeabarghouyi, M., & Nasirian, M. (2015). Effectiveness of acceptance and commitment therapy on cognitive emotional regulation in men under methadone maintenance treatment. *Journal of Shahid Sadoughi University of Medical Sciences and Health Services*, 23, 853–861.

Moyer, D. N., Page, A. R., McMakin, D. Q., Murrell, A. R., Lester, E. G., & Walker, H. A. (2018). The impact of Acceptance and Commitment Therapy on positive parenting strategies among parents who have experienced relationship violence. *Journal of Family Violence*, 33, 269-279. https://doi.org/10.1007/s10896-018-9956-5

Morton, J., Snowdon, S., Gopold, M., & Guymer, E. (2012). Acceptance and Commitment Therapy group treatment for symptoms of borderline personality disorder: A public sector pilot study. *Cognitive and Behavioral Practice*, 19(4), 527-544.

Murrell, A. R., & Scherbarth, A. J. (2006). State of the research & literature address: ACT with children, adolescents and parents. *International Journal of Behavioral Consultation and Therapy*, 2(4), 531.

Najjari, F., Khodabakhshi Koolaee, A., & Falsafinejad, M. R. (2017). The effectiveness of group therapy based on Acceptance and Commitment (ACT) on loneliness and psychological adjustment in women after divorce. *Journal of Torbat Heydariyeh University of Medical Sciences*, 5(3), 68-75.

Niles, A. N., Burklund, L. J., Arch, J. J., Lieberman, M. D., Saxbe, D., & Craske, M. G. (2014). Cognitive mediators of treatment for social anxiety disorder: Comparing Acceptance and Commitment Therapy and cognitive-behavioral therapy. *Behavior Therapy*, 45(5), 664-677.

O'Brien, K. M., Larson, C. M., & Murrell, A. R. (2008). Third-Wave Behavior Therapies for Children and Adolescents: Progress, Challenges, and Future Directions. *Acceptance and Mindfulness Treatments for Children and Adolescents: A Practitioner's Guide*. S. C. Hayes & L. A. Greco (Eds.), pp. 15-35. Oakland, CA: New Harbinger Publications.

Ossman, W., Wilson, K. G., Storaasli, R. D., & McNeill, J. W. (2006). A preliminary investigation of the use of Acceptance and Commitment Therapy in group treatment for social phobia. *International Journal of Psychology and Psychological Therapy*, 6, 397-416.

Öst, L. G. (2014). The efficacy of acceptance and commitment therapy: an updated systematic review and meta-analysis. *Behaviour Research And Therapy*, 61, 105-121.

Paliliunas, D. (2022). Values: A core guiding principle for behavior-analytic intervention and research. *Behavior Analysis in Practice*, 15(1), 115-125.

Pearson, A. N. (2009). Acceptance and Commitment Therapy (ACT) as a workshop intervention for body dissatisfaction and disordered eating attitudes. Unpublished Doctoral Dissertation. University of Nevada: Reno.

Pearson, A. N., Heffner, M., & Follette, V. (2010). *Acceptance and Commitment Therapy for Body Image Dissatisfaction*. Oakland, CA: New Harbinger Publications.

Petrovic, P., Ekman, C. J., Klahr, J., Tigerström, L., Rydén, G., Johansson, A. G., Sellgren, C., Golkar, A., Olsson, A., & Öhman, A. (2016). Significant grey matter changes in a region of the orbitofrontal cortex in healthy participants predict emotional dysregulation. *Social Cognitive and Affective Neuroscience*, 11(7), 1041-1049.

Pennefather, J., Hieneman, M., Raulston, T. J. et al., (2018). Evaluation of an online training program to improve family routines, parental well-being, and the behavior of children with autism. *Research in Autism Spectrum Disorders*. Vol. 54. pp. 21-26.

Poddar, S., Sinha, V. K., & Urbi, M. (2017). Impact of acceptance and commitment therapy on valuing behaviour of parents of children with neurodevelopmental disorders. *Psychology and Behavioral Science International Journal*, 3(3), 1–5. https://doi.org/10.19080/PBSIJ.2017.03. 555614

Porges, S. W. (2007). The polyvagal perspective. *Biological Psychology*, 74(2), 116-143.

Powers, M. B., Zum Vörde Sive Vörding, M. B., & Emmelkamp, P. M. (2009). Acceptance and commitment therapy: A meta-analytic review. *Psychotherapy and Psychosomatics*, 78(2), 73-80.

Prime, H., Andrews, K., Markwell, A., Gonzalez, A., Janus, M., Tricco, A. C., Bennett, T., & Atkinson, L. (2023). Positive parenting and early childhood cognition: A systematic review and meta-analysis of randomized controlled trials. *Clinical Child and Family Psychology Review*, 26(2), 362-400.

Prudenzi, A., Graham, C. D., Flaxman, P. E., Wilding, S., Day, F., & O'Connor, D. B. (2022). A workplace Acceptance and Commitment Therapy (ACT) intervention for improving healthcare staff psychological distress: A randomised controlled trial. PloS ONE, 17(4), e0266357.

Räsänen P, Lappalainen P, Muotka J, Tolvanen A, Lappalainen R. (2016). An online guided ACT intervention for enhancing the psychological well-being of university students: A randomized controlled clinical trial. *Behaviour Research and Therapy*. 78:30-42. https://doi: 10.1016/j.brat.2016.01.001

Quchani, M., Arbabi, F. H., & Smaeili, N. S. (2021). A comparison of the effectiveness of Clark and ACT parenting training on improving the emotional-behavioral problems of the child with divorced single mothers. *Learning and Motivation*, 76, 101759.

Rais, H. (2007). *Death of a Family Member: The Malay Grief Experiences Shared in Bereavement Support Group*. Institute of Education. Kuala Lumpur: International Islamic University Malaysia.

Ruiz, F. J. (2010). A review of Acceptance and Commitment Therapy empirical evidence: Correlational, experimental psychopathology, component and outcome studies. *International Journal of Psychology & Psychological Therapy*, 10(1), 125-162.

Ruiz, F. J., Flórez, C. L., García-Martín, M. B., Monroy-Cifuentes, A., Barreto-Montero, K., García-Beltrán, D. M., DianaRiaño-Hernández, M. A., Sierra, J. C., Suárez-Falcón, V.-B., & Gil-Luciano, B. (2018). A multiple-baseline evaluation of a brief acceptance and commitment therapy protocol focused on repetitive negative thinking for moderate emotional disorders. *Journal of Contextual Behavioral Science*, 9, 1–14.

Sachs, A. (2005). *Integrating acceptance with imaginal exposure to core schema: Process and outcome in generalised anxiety disorder*. (Unpublished doctoral dissertation): The University of Southern California, California.

Sağlam, M., & Aylaz, R. (2017). Çeşitli Değişkenler Açısından Boşanmış Bireylerin Özellikleri. *Journal of International Social Research*, 10(51).

Sancaklı, D. (2014). Boşanmış annelerin ve çocuklarının boşanma sürecine ilişkin yaşantıları. Yayınlanmamış Yüksek Lisans Tezi). Maltepe Üniversitesi, Sosyal Bilimler Enstitüsü, İstanbul.

Sarıot Ertürk, Ö. (2019). Positive parenting program: Effects on problem behaviors in preschool children and the mediating role of self-regulation skills. (Unpublished Doctoral Dissertation). Aydın Adnan Menderes University Social Sciences Institute, Aydın.

Savaşır, I., Şahin, N. H., & Kılıç, C. (2002). *Bilişsel davranışçı terapilerde değerlendirme: sık kullanılan ölçekler*. Ankara: Türk Psikologlar Derneği Yayınları.

Schaefer, E. S. (1965). Children's reports of parental behavior: An inventory. *Child Development*, 413-424.

Schaefer, M. R., Milman, L., Stover, C. S., & Berkowitz, S. J. (2018). Evidence for the efficacy of a therapeutic parenting intervention for a sample of youth affected by trauma and trauma-related disorders. *Journal of Family Violence*, 33(7), 457-468. https://doi:10.1007/s10896-018-9961-8

Seay, A., Freysteinson, W. M., & McFarlane, J. (2014). Positive parenting. In *Nursing Forum* (Vol. 49, No. 3, pp. 200-208).

Seligman, M. E. P. (2002). Positive psychology, positive prevention, and positive therapy. In *Handbook of Positive Psychology* (pp. 3-12). Oxford University Press.

Shaghaghi, F., & Shahfagr, Z. (2010). Comparative study of cognitive and thinking styles divorced women with normal women. *Journal of Behavioral Sciences*, *8*, 108-127.

Shankar (2014). *The effectiveness of acceptance and commitment therapy for severe anxiety and depression.* Unpublished small-scale research project. The University of Hertfordshire, Hertfordshire.

Shaw, D. S. (2006). Parenting programs and their impact on the social and emotional development of young children. In *Parenting skills* (pp. 1-5).

Shaw, D. S., & Gross, H. E. (2008). What we have learned about early childhood and the development of delinquency. In *The long view of crime: A synthesis of longitudinal research* (pp. 79-127). New York: Springer.

Shiralinia, K. H., Abdollahimousavi, H., & Khojastemehr, R. (2017). The effectiveness of group acceptance and commitment therapy-based training on parenting stress and psychological flexibility in mothers of children with autism spectrum disorder. *Psychology of Exceptional Individuals*, 7, 21–44. https://doi.org/10.22054/jpe.2018.26885.1695

Silk, J. S., Morris, A. S., Kanaya, T., & Steinberg, L. (2003). Psychological control and autonomy granting: Opposite ends of a continuum or distinct constructs? *Journal of Research on Adolescence*, 13(1), 113-128.

Smith, A. J. (2017). Acceptance and Commitment Therapy for Depression and Anxiety: An Interpretative Phenomenological Analysis of Clients' Experiences in a Group Context. School of Psychology Faculty of Life Sciences and Computing London Metropolitan University.

Soloff, P. H., Pruitt, P., Sharma, M., Radwan, J., White, R., & Diwadkar, V. A. (2012). Structural brain abnormalities and suicidal behavior in borderline personality disorder. *Journal of Psychiatric Research*, 46(4), 516-525.

Soo, C., Tate, R. L., & Lane-Brown, A. (2011). A systematic review of acceptance and commitment therapy (ACT) for managing anxiety: Applicability for people with acquired brain injury?. *Brain Impairment*, 12(1), 54–70. https://doi.org/10.1375/brim.12.1.54

Stoddard, J., & Afari, N. (2014). *The Big Book of ACT Metaphors: A Practitioner's Guide to Experiential Exercises and Metaphors in Acceptance and Commitment Therapy*. Oakland: New Harbinger Publications.

Stone, G., Clark, K., & McKenry, P. (2001). Qualitative evaluation of a parent education program for divorcing parents. *Journal of Divorce & Remarriage, 34*(1-2), 25-40. https://doi: 10.1300/J087v34n01_02

Strosahl, K. D., Hayes, S. C., Wilson, K. G., & Gifford, E. V. (2004). An ACT Primer. In S. C. Hayes & K. D. Strosahl (Eds.), *A Practical Guide to Acceptance and Commitment Therapy* (pp. 15-35). Springer, Boston, MA.

Sümer, N., Metin-Orta, İ., Alsancak-Akbulut, C., Salman-Engin, S., İlden-Koçkar, A., Şahin-Acar, B., Akkol-Solakoğlu, S., Aran, Ö., Selin Çakır, D., Kavaklı, B., Memişoğlu-Sanlı, A., Sağel-Çetiner, E., Türe, D., Üstünel, A. Ö., & Yaşar, B. (2020). Investigating the impact of a video-feedback intervention to promote positive parenting behaviors on maternal sensitivity in Turkey. *Turkish Journal of Psychology*, 35(85), 12-26.

Suárez, L., & Kaida, J. A. (2016). Enhancing cognitive flexibility in children with autism spectrum disorders: Evidence from a case study. *International Journal of Developmental and Educational Psychology*, 1(1), 57-64.

Şahin, M. (2021). The effect of Positive Parenting Program on children's behavior problems, parents' discipline methods, and parent-child relationship. Doctoral Dissertation. Hacettepe University.

Tamannaeifar, S., Gharraee, B., Birashk, B., & Habibi, M. (2014). A comparative effectiveness of acceptance and commitment therapy and group cognitive therapy for major depressive disorder. *Zahedan Journal of Research in Medical Science, 16,* 29-31.

Tani, S., Kawai, E., & Kitamura, K. (2013). ACT workshop for parents of children with developmental disabilities. *Ritsumeikan Journal of Human Sciences,* 28, 1–11.

Thompson, R. A. (1994). Emotion regulation: A theme in search of definition. *Monographs of the Society for Research in Child Development,* 59(2-3), 25-52. https://doi.org/10.1111/j.1540-5834.1994.tb01276.x

Tohumcu, K. (2024). İki Uçlu Bozukluk Hastalarında Kabul ve Kararlılık Terapisi Temelli Psikoeğitimin Psikolojik Esneklik ve Dürtüsellik Düzeylerine Etkisi. Doktora Tezi. Gaziantep Üniversitesi. Sağlık Bilimleri Enstitüsü. Hemşirelik Anabilim Dalı. Gaziantep.

Toprak, T. B., Arıcak, O. T., & Yavuz, K. F. (2020). Investigating the relationship between burnout level, psychological flexibility, and values among medical school students. *Journal of Cognitive Behavioral Psychotherapy and Research*, 9(1), 16-27.

TUIK. (2023). İstatistiklerle Kadın. https://data.tuik.gov.tr/Bulten/Index?p=Istatistiklerle-Kadin-2023-53675 Erişim Tarihi: 3.07.2024.

TUIK (2023). Evlenme ve Boşanma İstatistikleri. Erişim Tarihi: 3.07.2024.

Turner, J. J., Kopystynska, O., Schramm, D. G., & Higginbotham, B. (2019). Is one hour enough? Evaluating Utah's online divorce education course based on course length satisfaction. *Journal of Divorce & Remarriage, 60*(7), 537-551. https://doi:10.1080/10502556.2019.1586231

Twohig, M. P. (2012). Introduction: The basis of Acceptance and Commitment Therapy. *Cognitive and Behavioral Practice,* 19, 499-507. https://doi.org/10.1016/j.cbpra.2012.04.003

Twohig, M. P., & Levin, M. E. (2017). Acceptance and commitment therapy as a treatment for anxiety and depression: a review. *Psychiatric Clinics*, 40(4), 751-770.

Ulaşan Özgüle, E. T. (2011). The mediating role of self-regulation between parenting, attachment, and adjustment in middle adolescence. Middle East Technical University, Ankara.

Uğur, E. (2018). The effect of an Acceptance and Commitment Therapy-oriented psychoeducation program on fear of negative evaluation. Doctoral Dissertation.

Uğur, S. B. (2014). "Günümüzde Kadının Boşanma Deneyimleri: Akademisyen Kadınlar Üzerine Bir Araştırma", *Mediterranean Journal of Humanities.* 4(2), 293-326.

Ünaldı, N. (2016). Ebeveynler arası çatışma ve boşanmanın çocuklarda görülen psikiyatrik bozukluklar ile ilişkisi: Risk ve koruyucu faktörler. (Tıpta uzmanlık tezi). İstanbul Üniversitesi\Tıp Fakültesi, İstanbul.

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology*, 54, 40-50.

Vowles, K. E., Fink, B. C., & Cohen, L. L. (2014). Acceptance and Commitment Therapy for chronic pain: A diary study of treatment process in relation to reliable change in disability. *Journal of Contextual Behavioral Science*, 3(2), 74-80.

Wallerstein, J. S., & Lewis, J. M. (2004). The unexpected legacy of divorce: Report of a 25-year study. *Psychoanalytic psychology*, 21(3), 353.

Walser, R. D., Garvert, D. W., Karlin, B. E., Trockel, M., Ryu, D. M., & Taylor, C. B. (2015). Effectiveness of Acceptance and Commitment Therapy in treating depression and suicidal ideation in veterans. *Behaviour Research and Therapy*, 74, 25-31.

Walser, R. D., & Westrup, D. (2007). *Acceptance and Commitment Therapy for the Treatment of Post-Traumatic Stress Disorder and Trauma-Related Problems*. Oakland, CA: New Harbinger Publications.

Wardley, M., Flaxman, P., Willig, C., & Gillanders, D. (2014). 'Feel the feeling': Psychological practitioners' experience of acceptance and commitment therapy well-being training in the workplace. *Journal of Health Psychology*. https://doi.org/10.1177/1359105314557977

Waters, C. (2012). Acceptance and commitment therapy: Efficacy and mechanisms of therapeutic action. Unpublished Clinical Psychology Doctorate Thesis. Cardiff University, Cardiff.

Weber, H. (2001). Stress management programs. *Journal of Occupational Health Psychology*, 15184-15190.

Weiss, L., & Winslow, E. (2007). New Beginnings: An empirically-based intervention program for divorced mothers to help children adjust to divorce. In *Handbook of Parent Training: Helping Parents Prevent and Solve Problem Behaviors* (pp. 25-66).

White, R. G., Gumley, A. I., McTaggart, J., Rattrie, L., McConville, D., Cleare, S., & McLeod, H. J., Mitchell, G. (2015). Acceptance and Commitment Therapy for depression following psychosis: An examination of clinically significant change. *Journal of Contextual Behavioral Science*, 4(3), 203-209.

Wilson, K. G., Bordieri, M. J., Flynn, M. K., Lucas, N. N., & Slater, R. M. (2011). *Understanding acceptance and commit-ment therapy in context: A history of similarities and differences with other cognitive behavior therapies. Acceptance and Mindfulness in Behavior Therapy: understanding and applying the new therapies*. John Wiley and Sons.

WHO. (2024). Depressive disorder (depression). Retrieved June 7, 2024, from https://www.who.int/news-room/fact-sheets/detail/depression.

Wolchik, S. A., Sandler, I. N., Jones, S., Gonzales, N., Doyle, K., Winslow, E., Zhou, Q., & Braver, S. L. (2009). The New Beginnings Program for divorcing and separating families: Moving from efficacy to effectiveness. *Family Court Review*, 47(3), 416-435.

Yalom, I. (1970). *The theory and practice of group psychotherapy* (1st ed.). New York, NY: Basic Books.

Zarling, A., Lawrence, E., & Marchman, J. (2015). A randomized controlled trial of Acceptance and Commitment Therapy for aggressive behavior. *Journal of Consulting and Clinical Psychology*, 83(1), 199.

Zhang, Z., Leong Bin Abdullah, M. F. I., Shari, N. I., & Lu, P. (2022). Acceptance and commitment therapy versus mindfulness-based stress reduction for newly diagnosed head and neck cancer patients: a randomized controlled trial assessing efficacy for positive psychology, depression, anxiety, and quality of life. *PLoS ONE*, 17(5), e0267887.

Zettle, R. D. (2007). *ACT for Depression: A Clinician's Guide to Using Acceptance and Commitment Therapy in Treating Depression*. Oakland, CA: New Harbinger Publications.

Zettle, R. D., & Rains, J. (1989). Group cognitive and contextual therapies in treatment of depression. *Journal of Clinical Psychology, 45*, 438-445.

Zettle R. D. & Hayes S. C. (1986). Dysfunctional control by verbal behavior. The context of reason-giving. *The Analysis of Verbal Behavior, 4*, 30-38.

7. APPENDICES

Appendix 1: Demographic Form

1. Yaşınız:
2. Cinsiyetiniz:
   - Kadın
   - Erkek
3. Eğitim Durumunuz: (Tamamladığınız son eğitim düzeyi)
   - Okur-yazar
   - İlköğretim mezunu
   - Lise mezunu
   - Önlisans mezunu
   - Lisans mezunu
   - Yüksek lisans mezunu
   - Doktora mezunu
4. Mesleğiniz nedir? ……..
5. Kaç çocuğunuz vardır? Çocukların yaşları nelerdir?
6. Çocuklarınızın yaşlarını küçükten büyüğe sırasıyla yazınız.
7. Kaç yıl evli kaldınız?
   - 1 yıldan az
   - 1-5 yıl
   - 6-10 yıl
   - 11-15 yıl
   - 16 -20 yıl
   - 21-25 yıl
   - 26 yıl ve üzeri
8. Resmi boşanma tarihiniz: …..
9. Boşanma kararını kim verdi?
   - Ben verdim
   - Eşim verdi
   - Birlikte karar verdik
   - Diğer

10. Boşanma süreci ile birlikte çalışma durumunuz nasıl etkilendi?

Çalışmıyordum, hala çalışmıyorum.

Çalışmıyordum ama artık çalışıyorum.

Çalışıyordum, hala çalışıyorum.

Çalışıyordum ama artık çalışmıyorum.

11. Boşanma sürecinden sonra nafaka aldınız mı? (Birden fazla işaretleyebilirsiniz.)

Tedbir nafakası (dava devam ederken alınan nafaka)

İştirak nafakası (çocuk için alınan nafaka)

Yoksulluk nafakası (boşanma sebebiyle yoksulluğa düşecek tarafa ödenen nafaka)

Hiçbiri

12. Boşanma sürecinden sonra nafaka verdiniz mi? (Birden fazla işaretleyebilirsiniz.)

Tedbir nafakası (dava devam ederken alınan nafaka)

İştirak nafakası (çocuk için alınan nafaka)

Yoksulluk nafakası (boşanma sebebiyle yoksulluğa düşecek tarafa ödenen nafaka)

Hiçbiri

13. Boşanmada ev, araba vb (varsa) mal paylaşımı taraflar arasında nasıl gerçekleşti? ……

14. Çocuğunuzun/çocuklarınızın velayeti kimde?

Annede

Babada

Diğer …..(açıklayınız)

15. Çocuğunuzun/çocuklarınız kim ile birlikte yaşıyorlar?

Benimle birlikte

Diğer ebeveyni ile birlikte

Diğer …..(açıklayınız)

16. Boşandıktan sonra hayatınızın hangi alanında değişiklikler oldu? Lütfen kutulara çarpı işareti koyunuz. Birden fazla kutuyu işaretleyebilirsiniz.

Yaşadığım ev

Evlatlarımla ilişkim

İşim

Evdeki düzenim

Arkadaşlarımla ilişkim

Sağlığım

17. Boşandıktan sonra kimlerden sosyal destek aldınız? Lütfen kutulara çarpı işareti koyunuz. Birden fazla kutuyu işaretleyebilirsiniz.

Anne

Baba

Evlat

Kardeş

Akraba

Arkadaşlar

Kendim

Hiç kimse

18. Sigara kullanıyor musunuz?

Evet

Hayır

19. Alkol kullanıyor musunuz?

Evet

Hayır

20. Evet ise ne sıklıkta? (Düzenli alkol kullananların grup oturumları öncesinde alkol kullanmamış olması gerekmektedir.)….

21. Psikiyatrik ilaç kullanıyor musunuz? (Çalışma sürecinde ilaç kullanım durumunuzu değiştirmemenizi ve böyle bir durumda ilgili araştırmacı bildirmenizi rica ederiz.)

Evet

Hayır

22. Halen kullandığınız bir psikiyatrik ilaç varsa aldığınız tanıyı ve kullandığınız ilacı yazınız.……..

23. Boşandıktan sonra yaşadığınız sorunlar için hiç bireysel danışmanlık veya psikoterapi aldınız mı?

Hayır

Evet ise ne zaman kimden?

Appendix 2: Psychological Flexibility Scale

Aşağıda psikolojik esneklik düzeyinizi ölçmeye ilişkin ifadeler yeralmaktadır. Sizden, kendi yaşantınızı dikkate alarak aşağıdaki ifadeleri değerlendirmeniz istenmektedir. Her bir maddeye katılma durumunuza göre 7 aralıklı ölçek üzerinde, ilgili rakam üzerine çarpı (X) koyarak gösteriniz.

		1	2	3	4	5	6	7
1.	Benim için neyin önemli olduğunu ve hayatımda gelmek istediğim noktayı biliyorum.							
2.	Duygu ve düşüncelerin ortaya çıkmasını engellemek için bir şeylerle meşgul olmaya çalışırım.							
3.	Olumsuz duygular hissettiğimde dikkatimi dağıtmaya çalışırım.							
4.	Duygu ve düşüncelerimi değiştirmeksizin, onları olduğu gibi kabullenebilirim.							
5.	Zorlayıcı duygu, düşünce veya hisleri ortaya çıkarabilecek durumlardan kaçınmaya çalışırım.							
6.	Üzüntü verici duyguları uzak tutmak için elimden geleni yaparım.							
7.	Stresli olsa bile, tercihlerimi benim için neyin önemli olduğuna dayanarak yaparım.							
8.	İş veya görevlerimi, ne yaptığımın farkında olmaksızın, otomatik bir şekilde yaparım.							
9.	Yaşamayı seçtiğim önemli değerlere sahibim.							
10.	Duygu ve düşüncelerimi kontrol etmek yada onlardan kaçınmak yerine, onları olduğu gibi kabul edebilirim.							
11.	Düşünceler sadece düşüncelerdir, yaptıklarımı kontrol etmezler.							
12.	Aklıma gelen düşünce, duygu ve hisler ne olursa olsun, onları değiştirmeden ve onlara karşı çıkmadan tam anlamıyla deneyimlemeye razıyım.							
13.	Kişisel değerlerim doğrultusunda hareket ederim.							
14.	Düşüncelerime öyle takılırım ki en çok yapmak istediğim şeyleri yapamam.							
15.	Düşüncelerimin, yapmak istediğim şeyleri engellemesine izin vermem.							

16.	Yapması zor olsa bile, benim için anlamlı olan şeylerin sorumluluğunu alırım.							
17.	Kendim hakkındaki bir düşüncemetam olarak uymak zorunda değilim.							
18.	Ne yaptığımın pek farkında olmadan otomatik hareket ediyormuşum gibi görünür.							
19.	Hayatta benim için gerçekten önemli olan şeyleri belirler ve onların peşinden giderim.							
20.	Benim için anlamlı olan etkinlikleri çok dikkatimi vermeden aceleyle yaparım.							
21.	Bir şey benim için önemli ise onu yapmaya devam edebilirim.							
22.	Şu anda yaşananlara odaklanmakta zorlanırım.							
23.	Geçmiş ya da gelecek ile çok meşgul olduğumdan, kendimi şu an olanları kaçırırken bulurum.							
24.	En büyük hedeflerimden biri bana acı veren duygularımdan kurtulmaktır.							
25.	Benim için oldukça önemli olsalarda, kendimi, o işi dikkatimi vermeden yaparken bulurum.							
26.	Değerlerim, davranışlarıma tamamıyla yansır.							
27.	İlerleme yavaş olsa bile, zaman gerektiren uzun vadeli planlarıma sadık kalabilirim.							
28.	Hayatımı nasıl yaşamak istediğimle uyumlu bir şekilde hareket ederim.							

Appendix 3: Emotion Regulation Questionnaire

Aşağıda insanların duygularını kontrol etmekte kullandıkları bazı yöntemler verilmiştir. Lütfen her durumu dikkatlice okuyunuz ve her birinin sizin için ne kadar doğru olduğunu içtenlikle yanıtlayınız. Yanıtınızı uygun cevap önündeki yuvarlak üzerine çarpı (X) koyarak işaretleyiniz.

1. Duygularımı içinde bulunduğum durum hakkındaki düşüncelerimi değiştirerek kontrol ederim.	1	2	3	4	5	6
2. Hissettiğim olumsuz duyguları azaltmak istediğimde, içinde bulunduğum durum hakkındaki düşüncelerimi değiştiririm.	1	2	3	4	5	6
3. Hissettiğim olumlu duyguları arttırmak istediğimde, içinde bulunduğum durum hakkındaki düşüncelerimi değiştiririm.	1	2	3	4	5	6
4. Hissettiğim olumlu duyguları (sevinç veya eğlence/çoşku gibi) arttırmak istediğimde, düşündüğüm şeyleri değiştiririm.	1	2	3	4	5	6
5. Hissettiğim olumsuz duyguları (üzüntü veya kızgınlık gibi) azaltmak istediğimde, düşündüğüm şeyleri değiştiririm.	1	2	3	4	5	6
6. Stres yaratan bir durumla karşılaştığımda, sakin kalmama yardımcı olacak şekilde düşünmeye çalışırım.	1	2	3	4	5	6
7. Duygularımı onları belli etmeyerek kontrol ederim.	1	2	3	4	5	6
8. Olumsuz duygular hissettiğimde, onları belli etmemek için elimden geleni yaparım.	1	2	3	4	5	6
9. Duygularımı kendime (içimde) saklarım.	1	2	3	4	5	6
10. Olumlu duygular hissettiğimde, onları belli etmemeye özen gösteririm.	1	2	3	4	5	6

Appendix 4: Depression Anxiety Stress Scale

Son 1 Haftadaki durumunuzu belirtiniz.

		Hiç Uygun Değil	Biraz Uygun	Uygun	Çok Uygun
1.	Ağzımda kuruluk olduğunu fark ettim	0	1	2	3
2.	Soluk almada zorluk çektim (örneğin fizik egzersiz yapmadığım halde aşırı hızlı nefes alma, nefessiz kalma gibi)	0	1	2	3
3.	Geçerli bir neden olmadığı halde korktuğumu hissettim.	0	1	2	3
4.	Panik haline yakın olduğumu hissettim	0	1	2	3
5.	Panikleyip kendimi aptal durumuna düşüreceğim durumlar nedeniyle endişelendim	0	1	2	3
6.	Vücudumda (örneğin ellerimde) titremeler oldu.	0	1	2	3
7.	Fiziksel egzersiz söz konusu olmadığı halde kalbimin hareketlerini hissettim (kalp atışlarımın hızlandığını veya düzensizleştiğini hissettim)	0	1	2	3
8.	Hiç olumlu duygu yaşayamadığımı fark ettim	0	1	2	3
9.	Hiçbir beklentimin olmadığı hissine kapıldım	0	1	2	3
10.	Birey olarak değersiz olduğumu hissettim	0	1	2	3
11.	Hayatın değersiz olduğunu hissettim	0	1	2	3
12.	Kendimi perişan ve hüzünlü hissettim	0	1	2	3
13.	Hiçbir şey bende heyecan uyandırmıyordu	0	1	2	3
14.	Bir iş yapmak için gerekli olan ilk adımı atmada zorlandım	0	1	2	3
15.	Olaylara aşırı tepki vermeye meyilliyim	0	1	2	3
16.	Kendimi gevşetip salıvermek zor geldi	0	1	2	3
17.	Sinirsel enerjimi çok fazla kullandığımı hissettim.	0	1	2	3
18.	Alıngan olduğumu hissettim.	0	1	2	3
19.	Gevşeyip rahatlamakta zorluk çektim.	0	1	2	3
20.	Beni yaptığım işten alıkoyan şeylere dayanamıyordum.	0	1	2	3
21.	Kışkırtılmakta olduğumu hissettim.	0	1	2	3

Appendix 5: Alabama Parenting Questionnaire

Sevgili anne babalar, aşağıda çocuk yetiştirme ile ilgili ifadeler vardır. Bu ifadelerin sizin için ne kadar uygun olduklarını size göre en doğru olacak şekilde her madde için ayrı ayrı işaretleyiniz. Lütfen aşağıdaki ifadeleri **sadece** ilkokulda devam eden çocuğunuzu dikkate alarak doldurunuz. Muhtemel cevaplar şöyledir: **Hiç, Neredeyse Hiç, Bazen, Sık Sık, Her Zaman**.

Lütfen ölçekteki **bütün maddeleri** cevaplayınız.

		Hiç	Neredeyse Hiç	Bazen	Sık Sık	Her Zaman
1.	Çocuğumla arkadaşça konuşurum.					
2.	Çocuğum iyi bir şey yaptığında bunu ona söylerim.					
3.	Çocuğumun sosyal aktivitelere katılmasını desteklerim.					
4.	Söylediklerimi yaptığında veya uslu durduğunda çocuğumu ödüllendiririm.					
5.	Çocuğumla oyun oynarım ya da onunla eğlenceli etkinlikler yaparım.					
6.	Çocuğuma okulda gününün nasıl geçtiğini sorarım.					
7.	Çocuğumun ödevlerini yapmasına yardım ederim.					
8.	İyi bir şey yaptığında çocuğumu takdir ederim.					
9.	Çocuğuma bir sonraki günüyle ilgili planlarını sorarım.					
10.	Çocuğumu sosyal etkinliklere götürürüm.					
11.	Akıllı durduğunda çocuğumu överim.					
12.	İyi bir şey yaptığında çocuğumu kucaklar veya öperim.					
13.	Çocuğumla arkadaşları hakkında konuşurum.					
14.	Çocuğum ailecek yapacağımız etkinliklerin planlanmasında fikrini söyler.					
15.	Çocuğumun veli toplantılarına katılırım.					
16.	Ev işlerinde yardım ettiğinde bundan memnun olduğumu çocuğuma söylerim.					

Appendix 6: Group Intervention Evaluation Form

Lütfen aşağıdaki soruları mümkün olduğunca dürüstçe cevaplayın.

	Çok İyi	İyi	Orta	Biraz	Hiç
1. Katıldığınız grubu ne kadar faydalı buldunuz?					
2. Grup liderini ne kadar yetkin buldunuz?					
3. Grupta ele alınan egzersizleri ve çalışmaları ne kadar yararlı buldunuz?					
4. Grupla ilgili genel memnuniyet seviyeniz nedir?					
5. Grubun **en çok** hangi yönlerini beğendiniz? (Detaylandırın)					
6. Grubun **en az** hangi yönlerini sevdiniz? (Detaylandırın)					
7. Değiştirilmesini veya farklı yapılmasını istediğiniz şeyler var mı ? Varsa nelerdir? (Detaylandırın)					
8. Lütfen paylaşmak istediğiniz herhangi bir geri bildiriminiz varsa paylaşın.					

Appendix 7: Qualitative Interview Form

1. Biraz sizi tanıyabilir miyim..
2. Boşanma sizin için ne ifade eder? Boşanmış bir kişi olmak, boşanmış …..Hanım/Bey olmak nasıl bir durum?
3. Boşanmış olduğunuzu en çok ne zamanlar hissedersiniz?
    - Bu durumlarda neler hisseder, nasıl tepki verirsiniz?
4. Boşandıktan sonra neler yaşadınız? Hayatınızı hangi alanlarda nasıl etkiledi? Neleri zorlaştırdı neleri kolaylaştırdı? Örnek verebilir misiniz?
    - Bu zorluklarla ilgili neler yaptınız? Neler bu süreçte işinizi kolaylaştırdı?
5. Tek ebeveyn olmak sizin için ne ifade eder? Tek ebeveynlik yapan bir kişi olmak nasıl bir durum?
6. Tek ebeveyn olduğunuzu en çok ne zamanlar hissedersiniz?
    - Bu durumlarda neler hisseder, nasıl tepki verirsiniz?
7. Tek ebeveynlik ile ilgili sorun yaşadığınız zamanlarda neler yapmak kendinizi daha iyi hissettirir?
8. Gün içerisinde duygularınızda inişler, çıkışlar, ani değişiklikler olur mu? Örnek verebilir misiniz?
    - Olursa bu hangi durumlarda, hangi ortamlarda olur?
    - Böyle durumlarda siz neler yaparsınız? Örnek verebilir misiniz?
    - Bu durumlarda yaptığınız şeylerin nasıl bir işlevi oluyor? / Size nasıl geliyor?
7. Son zamanlarda en yoğun hissettiğiniz duygu hangisidir?
    - Sizi (bahsettiği duygu) ..... hissettiren şeyler genellikle neler olur? Hangi durumlarda daha çok böyle hissedersiniz?
    - Böyle yoğun bir şekilde (bahsettiği duygu)…….. hissettiğinizde neler yaparsınız?
    - Bu durumlarda yaptığınız şeylerin nasıl bir işlevi oluyor? / Size nasıl geliyor?
8. Ne olursa bu probleminizin ortadan kalktığını düşünürsünüz?
9. Değiştirme imkânınız olsaydı hayatınızda neyi değiştirirdiniz? Neden?
10. Ele almadığımız ancak sizin paylaşmak istediğiniz herhangi bir şey var mı?

Görüşmeye katıldığınız ve zaman ayırarak görüşlerinizi paylaştığınız için teşekkür ederim.

Appendix 8: Informed Consent Form

LÜTFEN BU DÖKÜMANI DİKKATLİCE OKUMAK İÇİN ZAMAN AYIRINIZ

Sizi Prof. Dr. Hüdayar CIHAN danışmanlığında Uzman Klinik Psikolog Sibel ARSLAN tarafından yürütülen " Boşanmış Ebeveynlere Yönelik Kabul ve Kararlılık Terapisi Temelli Grup Müdahale Programı" 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 çalışmada boşanmış ebeveynlere yönelik geliştirilen Kabul ve Kararlılık Terapisi (ACT) temelli grup müdahale programının psikolojik esneklik, duygu düzenleme becerileri, depresyon kaygı ve stres düzeyleri ile olumlu ebeveynlik davranışları üzerindeki etkisinin belirlenmesi amaçlanmaktadır.
b. Araştırmanın İçeriği: Çalışma 8 hafta boyunca hafta bir kez uygulanacak 15'şer kişiden oluşan grup müdahalesini içermektedir.
c. Araştırmanın Nedeni: Tez çalışması
d. Araştırmanın Öngörülen Süresi: 12 ay
e. Araştırmaya Katılması Beklenen Katılımcı/Gönüllü Sayısı: 72
f. Araştırmanın Yapılacağı Yer(ler): Online Platform (GoogleMeet)

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.

Araştırmacının;
Adı-Soyadı: Sibel ARSLAN
İmzası:

AYBU ETİK Form 2
Y.T. / REV. : 12.202021/ 00

Appendix 9: Ethical Committee Approval

ANKARA YILDIRIM BEYAZIT UNIVERSITY (AYBU)
SOCIAL AND HUMAN SCIENCES ETHICS COMMITTEE
RESEARCH PROJECT APPROVAL DOCUMENT

Ankara Yıldırım Beyazıt University Social Sciences Institute Department of Psychology from students Sibel ARSLAN's, Act-Based Group Interventions for Divorced Single Parents: A Randomized Control Trail titled research was evaluated. *(This part must be filled by the applicant)*

The project was approved in terms of ethics. [X]
The project needs to be re-submitted in terms of ethics. [ ]
The project was rejected in terms of ethics. [ ]

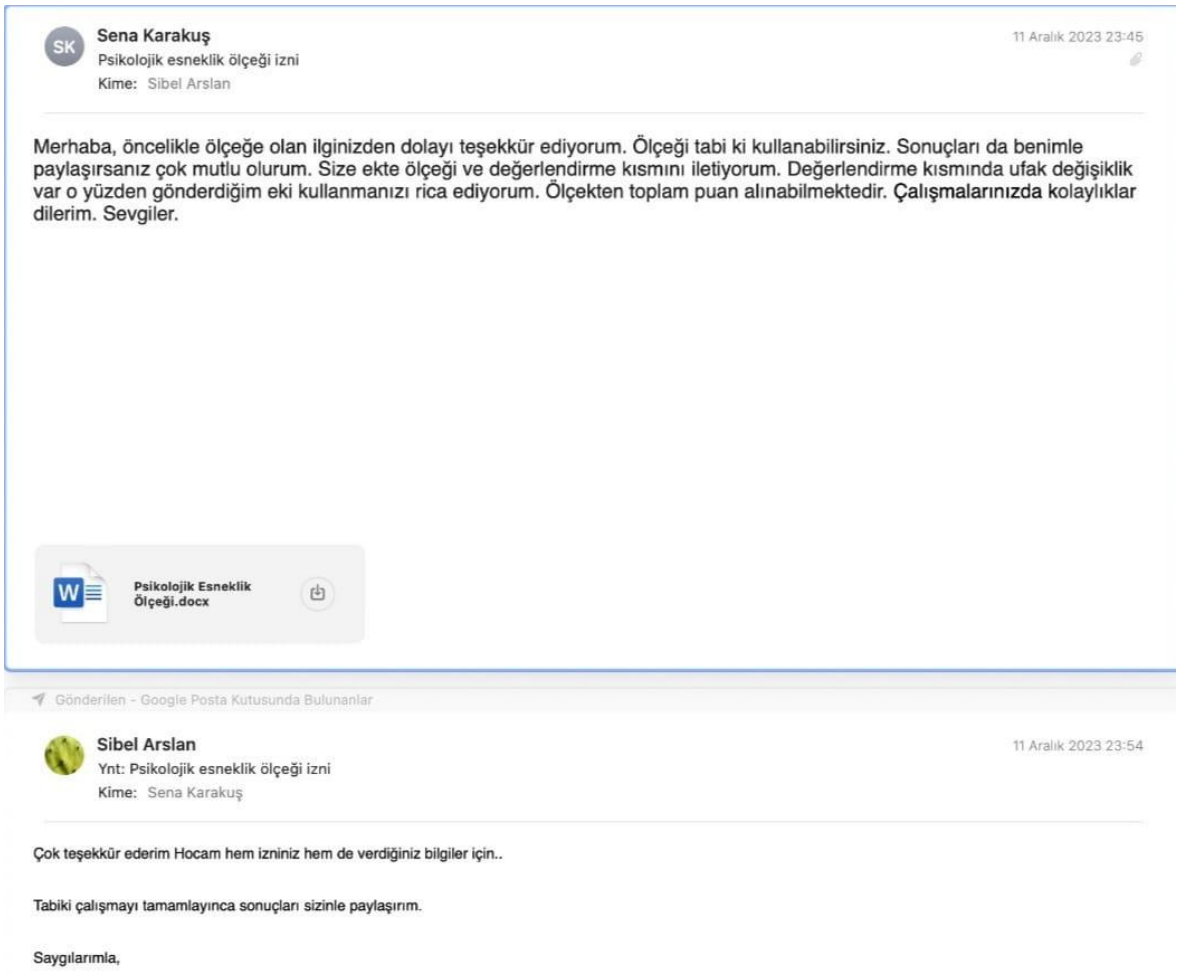
AYBU SOCIAL AND HUMAN SCIENCES ETHICS COMMITTEE DECISION (To be filled by the Ethics Committee)	
Research code (Year – Research order number)	2023-85
The date the application form was received by the Ethics Committee	10.04.2023
Ethics Committee Decision meeting date and decision number	12.04.2023/04-85
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. Hakkı ODABAŞ	Chairman	
Prof. Dr. Musa ÖZTÜRK	Member	
Assoc. Dr. Ömer ASLAN	Member	
Assoc. Dr. Özge GÖKBULUT ÖZDEMİR	Member	
Assoc. Dr. Ali POLAT	Member	
Assoc. Dr. Gülay YAZICI	Member	
Asst. Prof. Dr. Recep YORULMAZ	Member	
Asst. Prof. Dr. Semih CEYHAN	Member	
Asst. Prof. Dr. Keziban Büşra KAYNAK EKİCİ	Member	
Asst. Prof. Dr. Nur Betül ATAKUL	Member	
Asst. Prof. Dr. İrem ŞENGÜL	Member	

9

Appendix 10: Psychological Flexibility Questionnaire Usage Permission



Sena Karakuş 11 Aralık 2023 23:45
Psikolojik esneklik ölçeği izni
Kime: Sibel Arslan

Merhaba, öncelikle ölçeğe olan ilginizden dolayı teşekkür ediyorum. Ölçeği tabi ki kullanabilirsiniz. Sonuçları da benimle paylaşırsanız çok mutlu olurum. Size ekte ölçeği ve değerlendirme kısmını iletiyorum. Değerlendirme kısmında ufak değişiklik var o yüzden gönderdiğim eki kullanmanızı rica ediyorum. Ölçekten toplam puan alınabilmektedir. Çalışmalarınızda kolaylıklar dilerim. Sevgiler.

Psikolojik Esneklik Ölçeği.docx

Gönderilen - Google Posta Kutusunda Bulunanlar

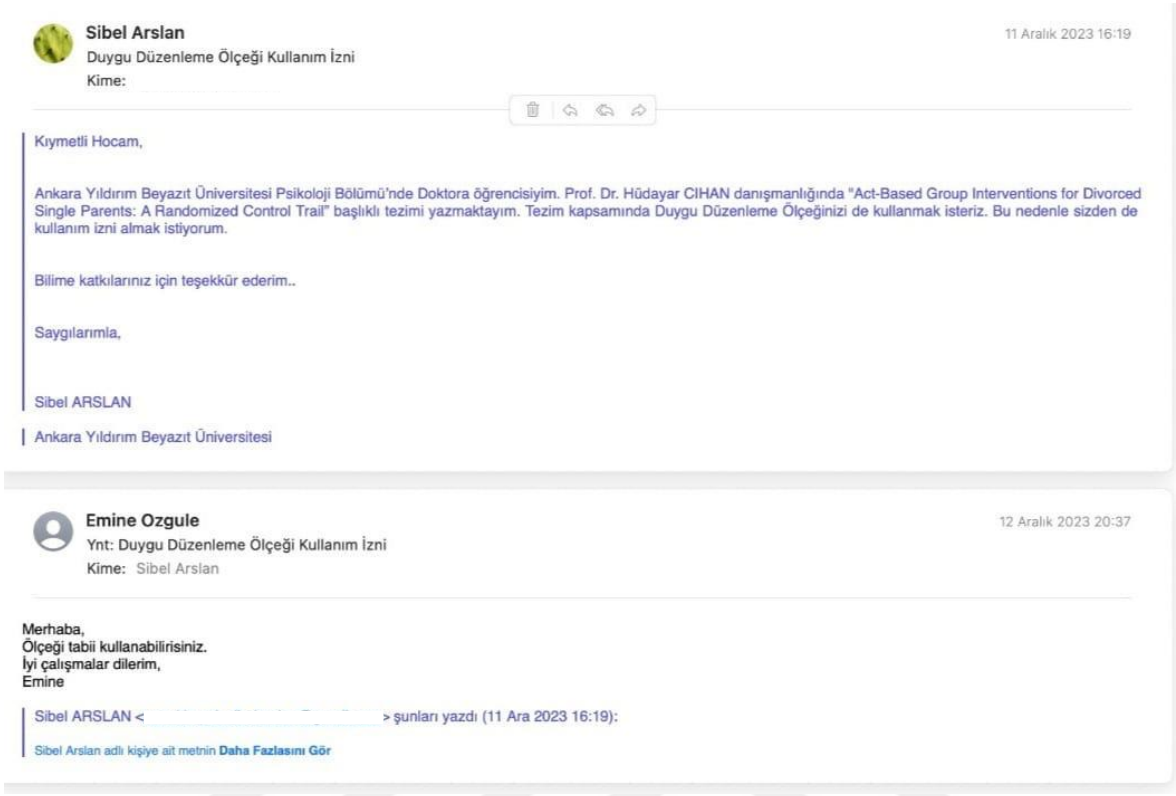
Sibel Arslan 11 Aralık 2023 23:54
Ynt: Psikolojik esneklik ölçeği izni
Kime: Sena Karakuş

Çok teşekkür ederim Hocam hem izniniz hem de verdiğiniz bilgiler için..

Tabiki çalışmayı tamamlayınca sonuçları sizinle paylaşırım.

Saygılarımla,

Appendix 11: Emotion Regulation Questionnaire Usage Permission



Sibel Arslan 11 Aralık 2023 16:19
Duygu Düzenleme Ölçeği Kullanım İzni
Kime:

Kıymetli Hocam,

Ankara Yıldırım Beyazıt Üniversitesi Psikoloji Bölümü'nde Doktora öğrencisiyim. Prof. Dr. Hüdayar CIHAN danışmanlığında "Act-Based Group Interventions for Divorced Single Parents: A Randomized Control Trail" başlıklı tezimi yazmaktayım. Tezim kapsamında Duygu Düzenleme Ölçeğinizi de kullanmak isteriz. Bu nedenle sizden de kullanım izni almak istiyorum.

Bilime katkılarınız için teşekkür ederim..

Saygılarımla,

Sibel ARSLAN

Ankara Yıldırım Beyazıt Üniversitesi

Emine Ozgule 12 Aralık 2023 20:37
Ynt: Duygu Düzenleme Ölçeği Kullanım İzni
Kime: Sibel Arslan

Merhaba,
Ölçeği tabii kullanabilirisiniz.
İyi çalışmalar dilerim,
Emine

Sibel ARSLAN < > şunları yazdı (11 Ara 2023 16:19):

Sibel Arslan adlı kişiye ait metnin **Daha Fazlasını Gör**

Appendix 12: Depression, Anxiety and Stress Scale Usage Permission

Sibel Arslan 11 Aralık 2023 16:25
DASS Kısa Form Kullanım İzni
Kime:

Kıymetli Hocam,

Ankara Yıldırım Beyazıt Üniversitesi Psikoloji Bölümü'nde Doktora öğrencisiyim. Prof. Dr. Hüdayar CIHAN danışmanlığında "Act-Based Group Interventions for Divorced Single Parents: A Randomized Control Trail" başlıklı tezimi yazmaktayım. Tezim kapsamında Depresyon Anksiyete ve Stress-Kısa Form ölçeğinizi de kullanmak isteriz. Bu nedenle sizden de kullanım izni almak istiyorum.

Bilime katkılarınız için teşekkür ederim..

Saygılarımla,

Sibel ARSLAN
Ankara Yıldırım Beyazıt Üniversitesi

ÖZER YILMAZ 18 Aralık 2023 23:09
Ynt: DASS Kısa Form Kullanım İzni
Kime: Sibel Arslan

Sayın Sibel Hanım;

Öncelikle çalışmanızda başarılar dilerim.

Çalışmanızda Türkçe formatının geçerlilik güvenilirlik çalışmasını yaptığımız DASS 21'i kullanmanızı memnuniyetle kabul ederiz.

Ölçekte yer alan soruların Türkçe formatları ve geçerlilik çalışmasına alttaki linkten ulaşabilirsiniz. (ölçek soruları çalışmanın 83 ve 84'te bulunmaktadır)

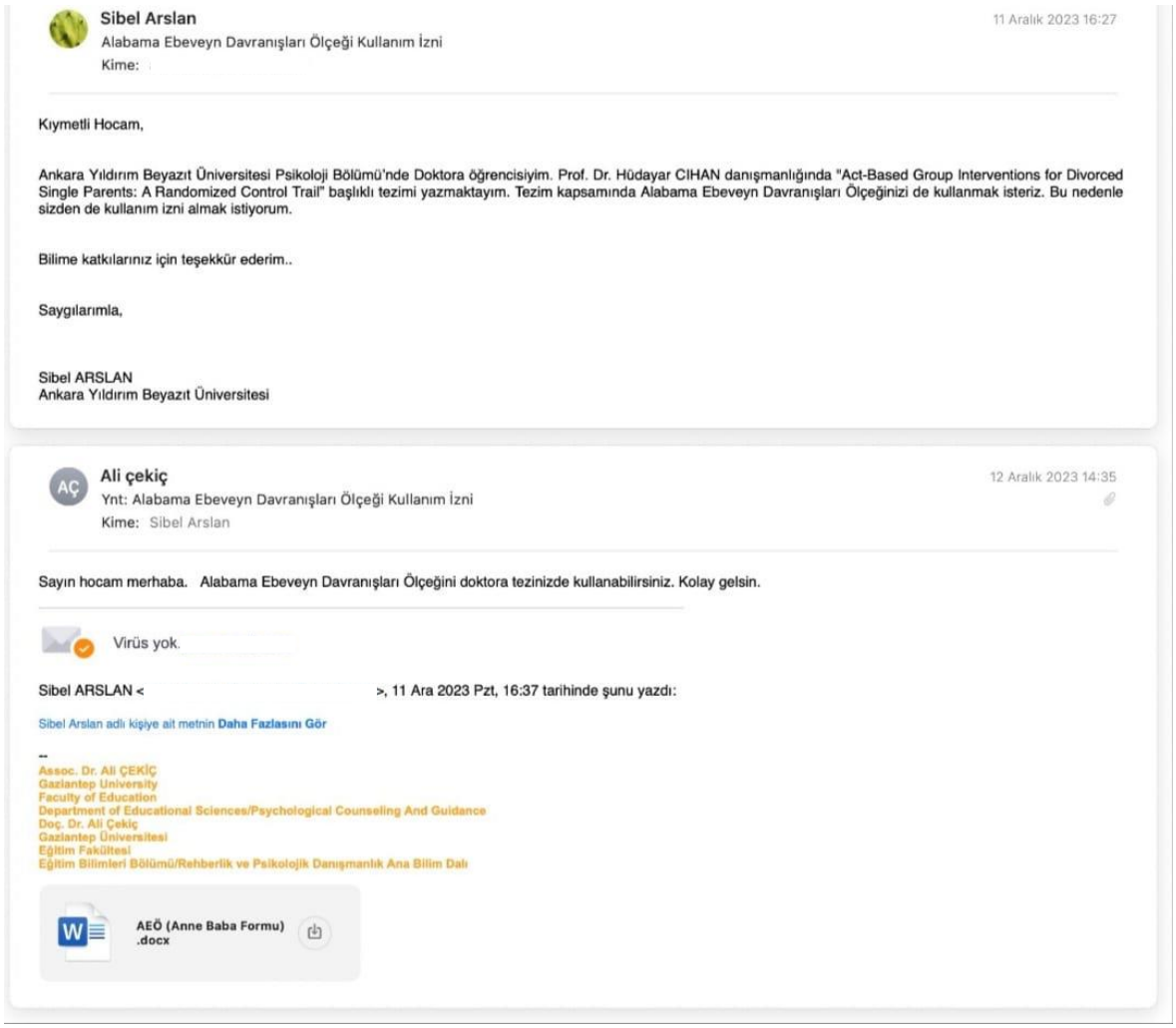
https://dergipark.org.tr/tr/download/article-file/354106

Ayrıca ölçek hakkında önemli bazı hususlar bulunmakta:

Ölçekte yer alan soruların sıralamasının bir önemi bulunmamakta. Ancak depresyon stres ve anksiyete sorularının karışık sorulması uygun olmaktadır. Orjinal ölçekte de (**Lovibond**, S.H. & **Lovibond**, P.F. (1995) ölçüm bu şekilde gerçekleştirilmiştir. Ölçekte Depresyon Stres ve Anksiyete için toplam puanlara göre değerlendirme yapılmaktadır. Ölçekte yer alan her madde belirtinin şiddetine göre 0, 1, 2 ya da 3 puana karşılık gelecek 4'lü bir puanlama sistemine sahiptir. Her boyutta minimum 0 maksimum 21 puan alınabilir. 42 maddelik (uzun form) DASS'ta puantajlar aşağıdaki gibidir.

	Depresyon	Anksiyete	Stres
NORMAL	0-9	0-7	0-14
HAFİF	10-13	8-9	15-18
ORTA	14-20	10-14	19-25

Appendix 13: Alabama Parenting Questionnaire Usage Permission



Sibel Arslan 11 Aralık 2023 16:27
Alabama Ebeveyn Davranışları Ölçeği Kullanım İzni
Kime:

Kıymetli Hocam,

Ankara Yıldırım Beyazıt Üniversitesi Psikoloji Bölümü'nde Doktora öğrencisiyim. Prof. Dr. Hüdayar CIHAN danışmanlığında "Act-Based Group Interventions for Divorced Single Parents: A Randomized Control Trail" başlıklı tezimi yazmaktayım. Tezim kapsamında Alabama Ebeveyn Davranışları Ölçeğinizi de kullanmak isteriz. Bu nedenle sizden de kullanım izni almak istiyorum.

Bilime katkılarınız için teşekkür ederim..

Saygılarımla,

Sibel ARSLAN
Ankara Yıldırım Beyazıt Üniversitesi

Ali çekiç 12 Aralık 2023 14:35
Ynt: Alabama Ebeveyn Davranışları Ölçeği Kullanım İzni
Kime: Sibel Arslan

Sayın hocam merhaba. Alabama Ebeveyn Davranışları Ölçeğini doktora tezinizde kullanabilirsiniz. Kolay gelsin.

Virüs yok.

Sibel ARSLAN < >, 11 Ara 2023 Pzt, 16:37 tarihinde şunu yazdı:

Sibel Arslan adlı kişiye ait metnin **Daha Fazlasını Gör**

--
Assoc. Dr. Ali ÇEKİÇ
Gaziantep University
Faculty of Education
Department of Educational Sciences/Psychological Counseling And Guidance
Doç. Dr. Ali Çekiç
Gaziantep Üniversitesi
Eğitim Fakültesi
Eğitim Bilimleri Bölümü/Rehberlik ve Psikolojik Danışmanlık Ana Bilim Dalı

AEÖ (Anne Baba Formu) .docx

Appendix 14: Program Invitation Announcement

