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Research Paper

Effectiveness of Trauma-focused Cognitive Behavioral Therapy on Guilt, Emotion Regulation, and Attachment Style in Women Victims of Domestic Violence

Fatemeh Talaiyan Pour[1], **Reza Davasaz Irani**[1*]

1. Department of Psychology, Ahv.C., Islamic Azad University, Ahvaz, Iran.

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ABSTRACT

Background: Domestic violence represents a pervasive global public health and human rights issue, inflicting profound physical, psychological, verbal, economic, sexual, and spiritual harm upon women.

Objectives: This study aimed to investigate the effectiveness of tauma-focused cognitive behavioral therapy (TF-CBT) in reducing guilt, improving emotion regulation, and modifying insecure (anxious and avoidant) attachment styles in women survivors of domestic violence.

Materials & Methods: This quasi-experimental study employed a pre-test/post-test design with a control group. The statistical population comprised all women victims of domestic violence referred to the Ahvaz Welfare Center in 2024. A convenience sample of 33 participants was selected based on inclusion criteria and randomly assigned to groups. The experimental group (n=16) received 8 ninety-minute sessions of trauma-focused cognitive behavioral therapy, while the control group (n=17) received no intervention. Data were collected using the guilt inventory, emotion regulation questionnaire, and the experiences in close relationships-revised. Data analysis was performed using analysis of covariance in SPSS software, version 27.

Results: The findings showed that trauma-focused cognitive behavioral therapy significantly reduced feelings of guilt ($F=443.33$, $P<0.001$), enhanced emotion regulation abilities ($F=130.14$, $P<0.001$), and effectively modified anxious ($F=633.98$, $P<0.001$) and avoidant ($F=239.39$, $P<0.001$) attachment styles in women victims of domestic violence.

Conclusion: This study provides robust evidence for the efficacy of trauma-focused cognitive behavioral therapy as a crucial intervention for improving mental health and fostering secure attachment in women affected by domestic violence. These results underscore the importance of integrating trauma-focused cognitive behavioral therapy into therapeutic protocols for this vulnerable population, offering a pathway toward enhanced psychological well-being and healthier interpersonal relationships.

*** Corresponding Author:**
Reza Davasaz Irani
Address: *Department of Psychology, Ahv.C., Islamic Azad University, Ahvaz, Iran.*
Tel: *+98 (61) 33348420*
E-mail: *rdavasazirani@gmail.com*

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Introduction

Domestic violence stands as a grave and pervasive global public health crisis and a severe violation of women's human rights [1]. Defined by the World Health Organization as any behavior within an intimate relationship that causes physical, psychological, sexual, or controlling abuse, it encompasses a range of harmful actions including physical and sexual aggression and coercion [2]. The pervasive nature of domestic violence is underscored by global statistics revealing that approximately one in three women worldwide experience physical or sexual violence from an intimate partner or non-partner sexual violence in their lifetime [3]. Alarmingly, in Iran, an estimated 66% of Iranian women report experiencing domestic violence during their married lives [4]. The profound and multifaceted impact of such destructive experiences on women extends beyond immediate physical harm, leading to a complex array of psychological, emotional, and cognitive challenges, often manifesting as post-traumatic symptoms, mood disturbances, and significant alterations in self-perception and relational patterns [5].

Experiences of severe trauma, such as domestic violence, expose women to a cascade of psychological difficulties, including profound alterations in their emotional states, behaviors, and thought processes [6]. A salient and often debilitating consequence is the pervasive feeling of guilt. Guilt, in this context, frequently arises when the traumatic event conflicts with an individual's core life rules and moral values, leading to self-blame and a sense of responsibility for the abuse they endured [7]. This moral injury can become deeply entrenched, exacerbated by societal and cultural narratives that sometimes inadvertently place blame on the victim [8]. Chronic guilt can severely impede recovery, fostering feelings of unworthiness and perpetuating a cycle of self-criticism, ultimately diminishing an individual's capacity for healing and adaptive functioning. The persistence of guilt is a significant barrier to rebuilding self-esteem and moving forward from the traumatic experience [9].

Another critical consequence of domestic violence is impaired emotion regulation [10]. Emotion regulation refers to an individual's ability to identify, process, manage, and modulate their emotions in an adaptive manner, employing both cognitive and behavioral strategies to navigate stressful situations and respond appropriately to negative emotions such as anger, anxiety, or sadness [11]. Women who have endured domestic violence often struggle with dysregulation, oscillating between emotional suppression and explosive outbursts, or experiencing heightened states of anxiety and depression [12]. This impairment can lead to impulsive reactions, emotional avoidance, and increased vulnerability to psychological disorders, further hindering their ability to form healthy relationships and cope with daily stressors [13]. Effective emotion regulation is crucial for resilience, psychological well-being, and adaptive interpersonal functioning.

Furthermore, domestic violence profoundly impacts an individual's attachment style [14]. Attachment styles, forged in early childhood through interactions with primary caregivers, dictate how individuals form and maintain emotional bonds throughout their lives, extending from family to friends and intimate partners [15]. Exposure to chronic trauma, such as domestic violence, often reinforces insecure attachment patterns, specifically anxious and avoidant styles [16]. Anxious attachment is characterized by a persistent fear of abandonment, excessive need for validation, and hypersensitivity to relational conflicts, often leading to clingy or desperate behaviors. Conversely, avoidant attachment manifests as emotional distancing, distrust of others, and suppression of attachment needs, typically adopted as a defense mechanism against repeated trauma [17]. Both insecure styles impede the formation of secure, trusting relationships and perpetuate cycles of relational distress, highlighting the critical need for interventions that address these deeply rooted patterns.

Trauma-focused cognitive behavioral therapy (TF-CBT) is a structured, evidence-based psychotherapy specifically designed to address the multifaceted needs of individuals affected by traumatic experiences, including domestic violence [18]. TF-CBT is a well-established therapeutic approach widely recognized for its efficacy in supporting individuals who have experienced trauma, such as physical abuse or post-traumatic stress disorder (PTSD) [19]. This evidence-based intervention integrates cognitive and behavioral techniques to address and modify maladaptive thought patterns, alleviate trauma-related symptoms—including guilt, shame, and anxiety—and enhance emotional regulation skills [20]. TF-CBT assists survivors in reframing unhelpful beliefs about themselves and others, reducing avoidant behaviors, and building resilience to manage distressing emotions effectively [21]. Research consistently demonstrates its effectiveness in reducing symptoms of PTSD and depression, while also improving self-efficacy and enhancing overall quality of life, particularly among women survivors [22, 23].

Given the high prevalence of domestic violence against women and its profound psychological repercussions, including chronic guilt, dysregulated emotions, and insecure attachment patterns, this research holds significant importance. Many victims face substantial barriers, such as cultural stigma and limited access to specialized services, while existing interventions often fail to adequately address the specific psychological needs of this vulnerable group. By focusing on the effectiveness of TF-CBT as a targeted approach, this study seeks to fill a critical gap in the Iranian research literature, providing scientific evidence for culturally adapted treatment protocols and supportive policies within welfare and social emergency centers. Furthermore, simultaneously examining the impact on guilt, emotion regulation, and attachment style offers a more comprehensive understanding of the mechanisms of recovery in this population, representing a notable innovation in trauma psychology. Therefore, the present study aims to answer the question: Is TF-CBT effective in reducing guilt, improving emotion regulation, and modifying attachment styles in women victims of domestic violence at the Ahvaz Welfare Center?

Materials and Methods

This study employed a quasi-experimental design, specifically a pre-test/post-test approach with a control group, to investigate the effectiveness of TF-CBT. The statistical population for this research included all women victims of domestic violence who sought assistance at the Ahvaz Welfare Center in 2024, totaling approximately 150 referrals based on center records. From this population, a convenience sample of 33 participants was carefully selected. The sample size was determined based on guidelines by Cohen [24], which recommend a minimum of 15 to 20 participants per group for sufficient statistical power in quasi-experimental designs, assuming a medium to large effect size. The slight difference in group sizes (16 in the experimental group and 17 in the control group) resulted from random assignment and one participant's withdrawal from the experimental group due to relocation, with no further attrition observed. Participants were randomly assigned to either the experimental group (n=16) or the control group (n=17).

Inclusion criteria for participants included women victims of domestic violence presenting to the Ahvaz Welfare Center, aged between 20 and 50 years, demonstrating trauma-related symptoms as per DSM-5 criteria, achieving a score above the mean on the domestic violence questionnaire, possessing at least basic literacy, and expressing willingness to participate in the study without receiving concurrent psychotherapy. Exclusion criteria comprised severe psychiatric disorders (e.g. psychosis, active substance abuse), active suicidal ideation, attendance below 80% of the intervention sessions, and experiencing severe stressful life events during the study period. To encourage participant cooperation and attendance in the context of Ahvaz's cultural setting, where stigma around mental health and domestic violence is prevalent, strategies such as building trust through initial rapport-building sessions, offering flexible scheduling, and providing culturally sensitive psychoeducation were employed, as recommended by Kazemi Khooban et al. [23]. To control for confounding variables, the study standardized session delivery, ensured facilitator training, and monitored external stressors through regular check-ins, though complete control of variables like prior trauma history was not feasible. Ethical considerations were paramount throughout the research process. All participants provided informed consent, and their confidentiality and anonymity were strictly maintained. After baseline pre-test assessments for both groups, the experimental group received the intervention, while the control group did not, followed by post-test assessments. Following the conclusion of the study, the control group was offered the intervention in a condensed format.

Measure

Guilt inventory: The guilt inventory, developed by Jones et al. [25], is a 45-item self-report measure designed to assess various aspects of guilt comprehensively. Participants rate their agreement with each statement on a 5-point Likert scale, ranging from 1 ("strongly disagree") to 5 ("strongly agree"). The scoring ranges for the scales are from 45 to 225. Higher scores on the guilt subscales indicate a greater presence of guilt. Shahmiri et al. [26] reported a Cronbach's α of 0.74 for the instrument, indicating acceptable internal consistency. For the present study, the Cronbach's α for the Guilt Inventory was calculated to be 0.82, demonstrating acceptable reliability.

Emotion regulation questionnaire (ERQ): The ERQ, developed by Hofmann and Kashdan [27], is a 20-item self-report measure designed to assess an individual's habitual use of various emotion regulation strategies. Participants respond using a 5-point Likert scale, ranging from 1 ("not at all true for me") to 5 ("completely true for me"), with total scores ranging from 20 to 100. Higher scores indicate better emotion regulation abilities. A Persian validation study by Soleimani et al. [28] reported a Cronbach's α of 0.81, demonstrating good

internal consistency. In the present study, the overall Cronbach's α coefficient for the ERQ was 0.86, further confirming its reliability and validity for use with an Iranian sample.

Experiences in close relationships-revised (ECR-R): The ECR-R, developed by Fraley et al. [29], serves as a robust and widely utilized 36-item self-report measure for assessing adult attachment styles. This scale effectively differentiates between two continuous dimensions of insecure attachment: Anxiety and avoidance. The anxiety subscale, consisting of 18 items, evaluates the degree to which individuals worry about abandonment, rejection, or insufficient responsiveness from close others (e.g. "I often worry that my partner doesn't really love me"). The avoidance subscale, also with 18 items, measures the extent to which individuals feel uncomfortable with closeness and intimacy, preferring self-reliance and emotional distance (e.g. "I feel uncomfortable when others get too close to me"). Participants rate each statement on a 7-point Likert scale, ranging from 1 ("strongly disagree") to 7 ("strongly agree"). The score range for both the anxiety and avoidance subscales is from 18 to 126. Higher scores on either subscale indicate a greater degree of that specific insecure attachment pattern. In the Iranian standardization study conducted by Pooravari and Fathi Ashtiani [30], the Cronbach's α coefficient was reported as 0.81, indicating good internal consistency. In the present study, the ECR-R demonstrated strong internal consistency, with a Cronbach's α of 0.87.

Intervention

TF-CBT: The TF-CBT intervention, designed based on the structured protocol outlined by Cohen et al. [31], was administered to the experimental group over eight weekly 90-minute sessions. This structured therapy aims to address the multi-faceted impacts of trauma, including guilt, emotion dysregulation, and insecure attachment styles. The sessions systematically guided participants through various therapeutic components, building skills for emotional processing and cognitive restructuring. A summary of the sessions is provided in Table 1, outlining the topic, session title, and homework assignments for each week.

Data analysis

Data analysis was performed using analysis of covariance (ANCOVA) in SPSS software, version 27. Descriptive statistics, including Mean±SD, and frequency distributions, were calculated for all variables. Prior to conducting the ANCOVA, key statistical assumptions were thoroughly evaluated. Data normality was assessed using the Kolmogorov-Smirnov test, homogeneity of variances was examined with Levene's test, homogeneity of regression slopes was verified using an interaction term test between the covariate and the independent variable, and the assumption of linearity between pre-test and post-test scores was checked using scatterplots and Pearson correlation coefficients.

Results

The demographic analysis of the participants revealed that 53% of the subjects were in the age range of 20 to 32 years, while the remaining 47% fell into the 33 to 45-year age bracket. The mean age for the experimental group was 28.29±4.12 years, and for the control group, it was 33.18±5.37 years. This distribution indicates a relatively young adult sample, which is representative of women who may be experiencing domestic violence and seeking support at welfare centers. Table 2 presents the descriptive statistics, including Mean±SD, for the research variables (guilt, emotion regulation, and attachment styles) for both the experimental and control groups at pre-test and post-test. Additionally, the table includes the results of within-group (paired t-tests) and between-group (independent t-tests) comparisons for each construct.

Prior to conducting inferential analyses, the assumption of normality for the data distribution was assessed using the Kolmogorov-Smirnov test, with results indicating that the data for all research variables were normally distributed within both the experimental and control groups (all $P>0.05$). Additional ANCOVA assumptions were evaluated: Homogeneity of variances was confirmed using Levene's test (all $P>0.05$), equality of covariance matrices across groups was verified using Box's M test ($P=0.127$), and the assumption of sphericity was not applicable as each dependent variable was analyzed separately in univariate ANCOVA models. To determine the effectiveness of TF-CBT on the dependent variables (guilt, emotion regulation, anxious attachment style, and avoidant attachment style) after controlling for pre-test scores, an ANCOVA was performed. Before the ANCOVA, the assumptions of homogeneity of variances, assessed by Levene's test, and homogeneity of regression slopes were confirmed (all $P>0.05$). Table 3 presents the results of the ANCOVA, including effect sizes (partial η^2).

As shown in Table 3, the results of the ANCOVA revealed a statistically significant effect of TF-CBT on all dependent variables, after controlling for pre-test scores.

Table 1. Summary of treatment sessions for trauma-focused cognitive behavioral therapy

Session Number	Session Title	Session Topic	Homework Assignment
1	Introduction & interview	Initial introduction and establishment of therapeutic relationship; instilling a sense of hope; exploring various dimensions of experienced traumatic events; commitment to attending therapeutic sessions.	Familiarization with session content; commitment to attendance.
2	Preparation	Understanding psychological trauma and identifying types of emotions; training in emotional responses; preparing for emotional skills.	Identifying unpleasant situations and associated emotions.
3	Emotional skills	Training in emotional modulation skills, including identifying and grading emotions, and teaching emotional self-regulation.	Emotion regulation practice.
4	Relaxation skills	Teaching physical relaxation techniques: progressive muscle relaxation and deep breathing.	Physical relaxation practice.
5	Personal stories	Creating a trauma narrative and processing the post-traumatic experience; sharing the trauma.	Trauma recounting.
6	Emotional barriers	Examining guilt and attachment styles; identifying attachment styles and emotional and behavioral barriers.	Completing the emotions and attachment feelings chart.
7	Prevention & termination	Teaching coping strategies for various traumatic situations; developing a safety plan for different domestic violence risk situations; preparing women victims for treatment termination.	Providing assignments after treatment cessation.
8	Termination	Summarizing and reviewing past sessions; relapse prevention; concluding treatment.	Reviewing past session assignments + post-test.

Specifically, for guilt, there was a significant reduction in post-test scores in the experimental group compared to the control group ($F=443.33$, $P<0.001$, $\eta^2=0.94$). This large effect size suggests a substantial reduction in guilt, with clinical significance indicated by a mean decrease of 40.25 points in the experimental group, surpassing the threshold for meaningful change. Similarly, TF-CBT significantly improved emotion regulation ($F=130.14$, $P<0.001$, $\eta^2=0.83$), indicating a large effect and clinically meaningful improvement, as the experimental group's mean score increased by 35 points, reflecting enhanced adaptive emotion regulation strategies. Furthermore, the therapy significantly reduced anxious attachment style ($F=633.98$, $P<0.001$, $\eta^2=0.96$) and avoidant attachment style ($F=239.39$, $P<0.001$, $\eta^2=0.90$). These large effect sizes suggest clinically significant shifts toward secure attachment, as post-test scores for both anxious and avoidant subscales in the experimental group fell below the threshold for insecure attachment.

Discussion

This study aimed to investigate the effectiveness of TF-CBT in addressing key psychological sequelae in women survivors of domestic violence, specifically focusing on guilt, emotion regulation, and insecure attachment styles. The significant findings revealed that TF-CBT profoundly impacted all targeted variables, leading to a substantial reduction in guilt, a marked improvement in emotion regulation abilities, and a significant modification of both anxious and avoidant attachment styles. These results underscore the multidimensional efficacy of TF-CBT as a critical intervention for this vulnerable population.

The observed significant reduction in feelings of guilt among women survivors of domestic violence following TF-CBT aligns robustly with existing literature. This finding resonates with the work of Young et al. [32], who similarly reported that cognitive behavioral approaches are highly effective in alleviating trauma-related guilt. The efficacy can be attributed to TF-CBT's core principles of cognitive restructuring, which directly challenges distorted cognitions and maladaptive beliefs frequently held by victims, such as self-blame or a sense of responsibility for the abuse endured [21]. By systematically identifying and correcting these ingrained thought patterns, TF-CBT facilitates a healthier reinterpretation of the traumatic events, thereby diminishing the pathological sense of guilt and fostering a more accurate self-perception. Furthermore, the behavioral components of TF-CBT, including gradual exposure to trauma-related memories, enable emotional processing that can alleviate the emotional burden often associated with chronic guilt [32]. This process helps survivors break the cycle of avoidance and integrate the traumatic experience in a less self-condemnatory manner.

Consistent with our findings, TF-CBT demonstrably enhanced emotion regulation capacities in women affected by domestic violence, a result that is in harmony with previous research by Dumornay et al. [33] and Ford

Table 2. Pre-test and post-test scores of guilt, emotion regulation, and attachment styles in the two study groups

Variables	Groups	Mean±SD		P£
		Pre-test	Post-test	
Guilt	TF-CBT	156.19±7.79	115.94±7.00	<0.001
	Control	160.65±7.40	160.24±6.66	0.866
	P¥	0.102	<0.001	-
Emotion regulation	TF-CBT	60.69±7.16	95.69±9.85	<0.001
	Control	58.06±5.68	59.12±7.90	0.656
	P¥	0.250	<0.001	-
Anxious attachment style	TF-CBT	91.38±3.38	52.38±2.70	<0.001
	Control	91.29±3.53	91.59±3.60	0.801
	P¥	0.941	<0.001	-
Avoidant attachment style	TF-CBT	84.19±5.28	51.81±7.14	<0.001
	Control	84.94±3.69	86.06±5.77	0.501
	P¥	0.638	<0.001	-

TF-CBT: Trauma-focused cognitive behavioral therapy; £ Within-group comparison, ¥ Between-group comparison.

et al. [34]. This improvement can be primarily attributed to TF-CBT's emphasis on teaching adaptive emotional skills. Survivors of repeated trauma often develop maladaptive emotional responses, oscillating between emotional suppression and explosive outbursts [20]. The therapy addresses these dysregulated patterns by providing explicit training in emotion identification, distress tolerance, and cognitive reappraisal, which are vital for managing intense emotional reactions effectively [33]. By correcting distorted cognitive-emotional cycles, where distorted interpretations of events lead to disproportionate emotional responses, TF-CBT equips individuals with robust strategies to modulate their emotions adaptively [18]. Techniques such as controlled exposure to distressing stimuli gradually reduce emotional hypersensitivity, thereby increasing their capacity to manage tension and stress without resorting to maladaptive coping mechanisms [22].

Moreover, the study revealed that TF-CBT significantly modified insecure attachment styles, encompassing both anxious and avoidant dimensions, in women survivors of domestic violence. This outcome is consistent with the findings of Allen and Brown [35], who noted similar positive shifts in attachment patterns through attachment-focused interventions. TF-CBT's efficacy in this domain stems from its ability to impact deeply ingrained relational schemas that often underpin insecure attachment. For individuals with anxious attachment, the therapy challenges core beliefs like "I cannot survive

Table 3. Results of analysis of covariance on post-test scores of guilt, emotion regulation, and attachment styles

Variables	SS	df	MS	F	P	η^2
Guilt	14884.00	1	14884.00	443.33	<0.001	0.94
Emotion regulation	8869.06	1	8869.06	130.14	<0.001	0.83
Anxious attachment style	9039.01	1	9039.01	633.98	<0.001	0.96
Avoidant attachment style	8429.25	1	8429.25	239.39	<0.001	0.90

without a relationship" or "I am to blame for abuse", fostering a shift toward greater self-reliance and reduced fear of abandonment [16]. Through simulated relational scenarios and assertiveness training, survivors learn to articulate their needs without fearing relational rupture. For those with avoidant attachment, characterized by emotional distancing and distrust, TF-CBT works to reconstruct interpersonal trust and dismantle beliefs such as "trusting others leads to harm". By facilitating corrective emotional experiences within a safe therapeutic environment and promoting gradual engagement in healthy relationships, the therapy helps survivors build flexible boundaries and develop the capacity for secure attachment without fear of re-traumatization [35].

The comprehensive positive impact of TF-CBT on guilt, emotion regulation, and attachment styles highlights its potential as a holistic intervention for women survivors of domestic violence. These findings contribute significantly to the existing body of knowledge, particularly within the Iranian context, by providing empirical support for targeted, culturally sensitive therapeutic protocols. Integrating TF-CBT into welfare and social emergency centers can offer a pathway towards enhanced psychological well-being, fostering resilience, and promoting the development of healthier interpersonal relationships for this vulnerable population.

Conclusion

Based on the compelling findings of this study, TF-CBT is unequivocally demonstrated as a highly effective intervention for women victims of domestic violence. The significant reductions in guilt, substantial improvements in emotion regulation, and profound modifications of insecure attachment styles highlight TF-CBT's comprehensive capacity to ameliorate the complex psychological sequelae of intimate partner violence. These results underscore the critical importance of integrating TF-CBT into therapeutic protocols and support services, offering a robust pathway towards fostering resilience, promoting psychological well-being, and enabling healthier relational functioning for this vulnerable population.

Despite its promising results, this study faced certain limitations, including a relatively limited sample size, the inability to control for all potential intervening variables such as the duration and severity of experienced violence, and the lack of a long-term follow-up to assess the sustained effects of the intervention.

Ethical Considerations

Compliance with ethical guidelines

This study was granted ethical approval by the Ethics Committee of the Islamic Azad University, Ahvaz Branch, Iran (Code: IR.IAU.AHVAZ.REC.1404.077).

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Authors' contributions

All authors contributed equally to the conception and design of the study, data collection and analysis, interpretation of the results, and drafting of the manuscript. Each author approved the final version of the manuscript for submission.

Conflict of interest

The authors declared no conflict of interest.

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