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Original Article

Effectiveness of Mindfulness-based Cognitive Therapy (MBCT) on Depression, Suicidal Thoughts, Sleep Quality, and Self-esteem in Women with a History of Domestic Violence

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Abstract

Background and Objective: Domestic violence is one of the most serious risk factors for women's mental health, often leading to depression, suicidal ideation, sleep disturbances, and low self-esteem. The present study aimed to investigate the effectiveness of Mindfulness-Based Cognitive Therapy (MBCT) in reducing depression and suicidal thoughts, as well as improving sleep quality and self-esteem in women with a history of domestic violence.

Materials and Methods: The study employed a quasi-experimental design with pretest–posttest and follow-up phases, including a control group. A total of 45 women with a history of domestic violence were selected using purposive sampling and randomly assigned to experimental and control groups. The experimental group received eight weekly MBCT sessions, while the control group received no intervention. Data were collected using the Beck Depression Inventory (1961), the Beck Scale for Suicidal Ideation (1979), the Pittsburgh Sleep Quality Index by Buysse et al. (1989), and the Rosenberg Self-Esteem Scale (1965), and analyzed using multivariate analysis of covariance (MANCOVA).

Results: The results indicated that the intervention significantly reduced depression and suicidal ideation and improved sleep quality and self-esteem in both the posttest and follow-up phases ($p<0.01$).

Conclusions: These findings underscore the effectiveness of MBCT in alleviating the psychological consequences of domestic violence and support its application in support services for affected women.

Keywords: Depression, Domestic violence, Mindfulness-based cognitive therapy, Self-esteem, Sleep quality, Suicidal ideation

Background

Domestic violence is a complex, widespread, and multidimensional phenomenon that profoundly affects women's mental health and quality of life [1]. This type of violence, which may involve physical, psychological, sexual, economic, or verbal abuse, often occurs within intimate relationships and is perpetrated by a romantic partner or spouse [2]. According to a report by the Women's Health Research Center at Tehran University of Medical Sciences, Iran, more than 60% of Iranian women have experienced at least one form of domestic violence during their marital life [3]. The psychological consequences of such experiences include anxiety, feelings of insecurity, reduced self-confidence, and sleep disturbances, and in some cases, suicidal ideation [4]. Studies have shown that the severity and chronicity of domestic violence are directly related to the prevalence of mental disorders in women, and that effective supportive interventions can play a crucial role in preventing the onset of such disorders [3].

Among the psychological consequences of domestic violence, depression is one of the most prevalent and concerning disorders, severely undermining women's quality of life. Depression in women exposed to domestic violence often presents as chronic and treatment-resistant, accompanied by feelings of worthlessness, guilt, hopelessness, and low energy [5]. Women who are victims of domestic violence face a higher risk of developing depression due to continuous tension, lack of social support, and emotional trauma [6]. Evidence also indicates a significant correlation between depression in abused women and suicidal thoughts and behaviors [7]. Therefore, early identification and treatment of

depression in this population is considered a priority in mental health care [8].

Another common psychological consequence among women who have experienced domestic violence is impaired sleep quality, which has been identified as a key factor in reduced daily functioning and overall mental health [9]. The experience of violence—whether directly physical or psychological—leads to heightened physiological arousal and intrusive rumination, which in turn contribute to insomnia, nightmares, fragmented sleep, and early morning awakenings [10]. Abused women often report difficulties in falling asleep or an ongoing sense of insecurity even while asleep. Such sleep disturbances can exacerbate depression, lower emotional tolerance thresholds, and impair emotional processing [11, 12]. Recent research has also indicated that insomnia and poor sleep quality are associated with increased negative thinking, reduced cognitive performance, and deterioration in interpersonal functioning. In fact, sleep quality is not only a symptom of mental disorder but also serves as a sensitive indicator of mental health and treatment responsiveness [13]. Therefore, interventions aimed at improving sleep quality can play an important role in restoring the psychological well-being of affected women [14].

In addition to sleep disturbances, reduced self-esteem is another well-documented consequence of domestic violence that affects all dimensions of women's psychological, social, and functional lives [15]. Women with lower self-esteem are more likely to exhibit passivity, dependency, and repetitive engagement in unhealthy relational patterns. This factor plays a particularly critical role in the persistence of abusive relationships and the inability to leave them [16]. Research has shown that rebuilding self-esteem can strengthen decision-making capacity, increase motivation to leave harmful relationships, and improve women's psychosocial functioning [17]. Therefore, interventions focusing on self-esteem enhancement can serve as a foundation for reclaiming lost self-worth and promoting the psychological recovery of women exposed to domestic violence [18].

In response to the growing need for innovative therapies that take into account the lived experiences of individuals with a history of psychological trauma, Mindfulness-Based Cognitive Therapy (MBCT) has gained prominence as one of the third-wave interventions for mood disorders [19]. Initially developed by Segal, Williams, and Teasdale to prevent relapse in depression, in recent years, MBCT has been applied to the treatment of anxiety, intrusive thoughts, obsessive-compulsive disorder, suicidal ideation, and insomnia [20]. By combining traditional cognitive therapy techniques with mindfulness practices, such as body scan, mindful breathing, and nonjudgmental exposure to thoughts, MBCT helps clients develop a healthier relationship with negative thoughts, difficult emotions, and maladaptive behavioral patterns [21]. Recent studies have demonstrated that MBCT not only reduces depression and maladaptive emotions but also enhances self-efficacy [22, 23].

While many traditional treatments focus on symptom elimination, MBCT promotes sustainable recovery through fostering acceptance, emotional regulation, and self-awareness. Although global studies have confirmed the efficacy of MBCT, there remains a noticeable gap in research on its structured implementation among Iranian women with a history of domestic violence. In particular, few studies have simultaneously examined its effects on multiple psychological indicators such as depression, suicidal ideation, sleep quality, and self-esteem.

Objectives

The present study seeks to address this gap by investigating whether MBCT has a significant impact on depression, suicidal ideation, sleep quality, and self-esteem in women with experiences of domestic violence.

Materials and Methods

Research Design

The present study followed the protocols of an applied and quasi-experimental research, utilizing a pretest–posttest–follow-up design with a control group. The statistical population consisted of all women experiencing domestic violence who had active case files at the Rah Novin Baran Counseling Center in Yasuj (Iran) in 2024. Among them, 34 women who scored higher than 120 on the Domestic Violence Questionnaire [24] and met the inclusion criteria were selected through purposive sampling and randomly assigned to two groups (an experimental group and a control group).

Inclusion and Exclusion Criteria

Inclusion criteria comprised documented experience of domestic violence, informed consent to participate in the study, and not receiving other concurrent psychological treatments during the intervention period. Exclusion criteria included absence from more than two treatment sessions, use of psychiatric mood-stabilizing medications, and diagnosis of

severe psychiatric disorders as determined by a specialist or review of the clinical file.

Procedure

After obtaining informed consent, demographic information and pretest data were collected from participants. The women were then randomly allocated to the experimental group (e.g., MBCT) and the control group. The psychotherapy intervention was conducted according to Kabat-Zinn's (2003) standard protocol, adapted based on prior studies in Iran and validated for content relevance in women with a history of domestic violence [25]. The program consisted of eight weekly 90-min sessions. The control group received no intervention during this period. Posttest data were collected immediately after completion of the treatment, and follow-up data were gathered two months later.

Mindfulness-based Cognitive Therapy Protocol

The MBCT intervention combined classical cognitive therapy techniques with mindfulness-based practices, aiming to enhance nonjudgmental present-moment awareness, emotion regulation, and adaptive coping.

Instruments

Beck Depression Inventory (BDI)

The original version of this 21-item inventory was developed by Beck et al. (1961) to measure depressive symptoms. It includes three subscales, including (1) cognitive (items 3, 13, 14, 5, 6, 7, 8), (2) affective (items 1, 2, 4, 9, 12), and (3) somatic (items 15, 17, 19, 20, 10, 11, 16, 18, 21). Responses are rated on a four-point Likert scale ranging from 0 (strongly disagree) to 3 (strongly agree), with total scores ranging from 0 to 63. Reported internal consistency reliabilities for the subscales are 0.84, 0.79, and 0.80, respectively, and 0.85 for the entire scale; test–retest reliability over a five-week interval is 0.68 [26]. Rajabi et al. (2012) reported a Cronbach's alpha of 0.91 and a split-half reliability coefficient of 0.66 for the Persian version [27]. In the present study, Cronbach's alpha was 0.92 for the total score and ranged between 0.71 and 0.85 for the subscales.

Beck Scale for Suicidal Ideation (BSSI)

This 19-item self-report measure was developed by Beck (1988) to assess attitudes, thoughts, and plans for suicide. The first five items serve as a screening tool; a score of zero on all five items indicates the absence of suicidal ideation. Scores between 1 and 5 indicate the presence of suicidal thoughts, scores from 6 to 19 indicate suicidal readiness, and scores from 20 to 38 indicate intention to attempt suicide. The scale demonstrates high validity and reliability, with an internal consistency of 0.89 and interrater reliability of 0.83; concurrent validity with the Suicide Risk Scale is 0.69 [28]. The Persian version, validated by Esfahani et al. (2006), showed concurrent validity with the General Health Questionnaire of 0.76 and Cronbach's alpha of 0.95 [29]. In the present study, Cronbach's alpha for the total score was 0.91.

Pittsburgh Sleep Quality Index (PSQI)

Developed by Buysse et al. (1989) at the University of Pittsburgh Psychiatric Institute, the PSQI contains 19 items (including 10 sub-items in question 5) rated on a four-point Likert scale from 0 to 3. It measures seven components, including subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleep medication, and daytime dysfunction. Buysse et al. reported internal consistency of 0.83 and split-half reliability of 0.52 [30]. The Persian version showed a validity coefficient of 0.86 and a reliability of 0.89 [31]. In the present study, Cronbach's alpha was 0.79 for the total score and ranged from 0.65 to 0.81 for the subscales.

Rosenberg Self-Esteem Scale (RSES)

Developed by Rosenberg (1965), this 10-item measure assesses global self-esteem and personal worth. Items are rated dichotomously (agree/disagree). Scoring involves assigning +1 to agreement with items 1–5 and disagreement with items 6–10, and −1 to disagreement with items 1–5 and agreement with items 6–10. Higher total scores indicate higher self-esteem, with a range from −10 to +10. Scores above zero indicate high self-esteem, while scores below zero indicate low self-esteem; +10 represents very high self-esteem and −10 represents very low self-esteem. Rosenberg reported Cronbach's alpha coefficients of 0.87 for men and 0.86 for women in the first administration, and 0.88 for men and 0.87 for women in the second. Test–retest correlations range from 0.82 to 0.88, with internal consistency ranging from 0.77 to 0.88 [32]. The Persian version, validated by Abbasi et al (2024), demonstrated a split-half reliability of 0.73 and a 10-day test–retest correlation of 0.74 [33]. In the present study, Cronbach's alpha was 0.95 for the total score.

Data Analysis

After assessing the assumptions of statistical analyses, the data were analyzed using multivariate analysis of covariance (MANCOVA) using the SPSS (version 26) software.

Results

Demographic Characteristics

According to demographic findings, the mean (±SD) age of women in the MBCT experimental group was 35.05±7.64 years, while the mean ages were 34.41±5.94 and

34.70±7.55 years in the second experimental subgroup and the control group, respectively. Regarding education level, 52.9% of participants in the MBCT group, 47.1% in the second experimental subgroup, and 41.2% in the control group held a high school diploma or lower.

Descriptive Statistics

The means and standard deviations of depression, suicidal ideation, sleep quality, and self-esteem for each group at pretest, posttest, and follow-up are presented in Table 1.

Table 1. Means and standard deviations of study variables by group at three measurement points

Variable	Group	Pretest M ± SD	Posttest M ± SD	Follow-up M ± SD
Depression	MBCT	42.05 ± 6.38	30.52 ± 3.76	29.29 ± 3.58
	Control	42.82 ± 5.34	44.05 ± 5.21	45.11 ± 5.06
Suicidal Ideation	MBCT	36.47 ± 5.00	33.11 ± 4.45	32.11 ± 4.06
	Control	58.36 ± 4.06	38.00 ± 3.85	39.17 ± 4.27
Sleep Quality	MBCT	14.47 ± 1.84	11.64 ± 2.11	9.23 ± 2.63
	Control	14.52 ± 2.83	15.47 ± 2.50	16.00 ± 2.47
Self-esteem	MBCT	2.23 ± 1.14	3.29 ± 2.02	3.82 ± 2.48
	Control	2.35 ± 0.93	2.47 ± 1.28	2.35 ± 1.49

Assumption Testing

The results demonstrated that depression, suicidal ideation, sleep quality, and self-esteem at pretest, posttest, and follow-up met assumptions of normality, homogeneity of error variance, and equality of variance–covariance matrices. Mauchly's test of sphericity was significant; therefore, Greenhouse–Geisser corrections were applied in the final analysis.

Multivariate Analysis

Table 2 presents the results of the MANCOVA for depression, suicidal ideation, sleep quality, and self-esteem at posttest and follow-up. The findings indicated significant main effects for group, time, and the group×time interaction, suggesting that MBCT had a differential effect over time compared with the control group across all dependent variables.

Table 2. MANCOVA for Depression, Suicidal Ideation, Sleep Quality, and Self-esteem

Effect	Test	Value	F	df1	df2	p	Partial η^2
Group (MBCT vs. Control)	Pillai's Trace	0.86	36.42	4	27	0.001	0.86
Time (Pre, Post, Follow-up)	Pillai's Trace	0.88	67.53	8	23	0.001	0.88
Group × Time	Pillai's Trace	0.92	52.18	8	23	0.001	0.92

Univariate Analyses

Following the significant multivariate results, univariate ANCOVAs were performed for each dependent variable at posttest and follow-up (Table 3). The results demonstrated that, compared to the control group, participants in the MBCT group had significantly lower depression and suicidal ideation scores, better sleep quality (lower PSQI scores), and higher self-esteem scores at both posttest and follow-up (all $p<0.001$).

Table 4. Univariate ANCOVA Results for Study Variables at Posttest and Follow-up

Measure	SS	df	MS	F	p	Partial η^2
Posttest Depression	1438.780	2	719.390	125.215	0.001	0.851
Follow-up Depression	2054.772	2	1027.386	153.267	0.001	0.874
Posttest Suicidal Ideation	787.018	2	393.509	194.696	0.001	0.898
Follow-up Suicidal Ideation	1262.303	2	631.151	317.108	0.001	0.935
Posttest Sleep Quality	395.730	2	197.865	104.599	0.001	0.826
Follow-up Sleep Quality	977.426	2	488.713	142.445	0.001	0.866
Posttest Self-Esteem	31.876	2	15.938	14.394	0.001	0.396
Follow-up Self-Esteem	75.382	2	37.691	15.456	0.001	0.413

Effect Sizes

Partial eta-squared values indicated large effect sizes for depression (0.85–0.87), suicidal ideation (0.90–0.94), and sleep quality (0.83–0.87), and moderate-to-large effect sizes for self-esteem (0.40–0.41). Statistical power was 1.000 for all tests, indicating excellent statistical reliability and an adequate sample size for testing the study hypotheses.

Discussion

The present study aimed to examine the effectiveness of MBCT in reducing depression and suicidal ideation while improving sleep quality and self-esteem among women with a history of domestic violence. The results revealed that participants who underwent MBCT experienced significant improvements in all four outcomes at both the post-test and follow-up stages, compared to the control group. These findings confirm the therapeutic value of MBCT for addressing the psychological consequences of domestic violence.

The reduction in depression scores observed in the present study is consistent with previous evidence indicating that MBCT disrupts maladaptive cognitive patterns and reduces rumination, thereby alleviating depressive symptoms [25, 27]. In line with Arabi et al. (2024), MBCT appears to enable participants to observe negative thoughts without overidentifying with them, facilitating more adaptive responses [22]. The incorporation of mindfulness practices, such as body scanning and mindful breathing, likely contributed to increased emotional regulation and decreased cognitive reactivity to stressors [21].

The significant decline in suicidal ideation parallels earlier findings demonstrating the role of MBCT in reducing the intensity and frequency of suicidal thoughts by enhancing present-moment awareness and acceptance [29]. In the present work, the ability to reframe thoughts as transient mental events may have helped participants distance themselves from self-destructive cognitions. This mechanism is particularly relevant in survivors of domestic violence, where hopelessness and negative self-evaluation are common risk factors for suicidal thinking [17,1].

The observed improvement in sleep quality aligns with research suggesting that mindfulness-based approaches reduce physiological hyperarousal and promote restorative rest [14, 31]. Women who have experienced domestic violence often report heightened vigilance, nightmares, and difficulty initiating sleep [11, 13]. In the present study, practices like mindful breathing and the three-minute breathing space may have mitigated these symptoms by fostering relaxation and attentional control, thereby improving subjective sleep quality.

Similarly, the enhancement of self-esteem following MBCT supports previous research showing that mindfulness training fosters self-acceptance and reduces self-critical thinking [15, 33]. Survivors of domestic violence frequently internalize degrading messages from abusive relationships, leading to diminished self-worth [5, 9]. Through MBCT, participants learned to identify and challenge such self-defeating narratives, replacing them with more balanced and compassionate self-perceptions.

Mindfulness disrupts automatic avoidance strategies and encourages nonjudgmental engagement with internal experiences, while cognitive techniques target and modify distorted beliefs [19]. Furthermore, the group-based delivery format may have provided a supportive social context, reducing feelings of isolation and enhancing treatment engagement [6].

Clinically, these results underscore the value of incorporating MBCT into support services for women affected by domestic violence. Its structured, time-limited format and emphasis on self-practice make it feasible for implementation in community and counseling settings, even in resource-limited contexts [4].

Nevertheless, certain limitations should be acknowledged. The study relied exclusively on self-report measures, which may be influenced by social desirability bias. Additionally, the sample was recruited from a single counseling center, which may limit its generalizability. Future studies should involve larger and more diverse samples, integrate objective sleep measures, and assess the long-term effectiveness of MBCT beyond the follow-up period. Comparative research between MBCT and other evidence-based interventions, such as forgiveness-based schema therapy [8], may further clarify its relative benefits for this population.

Conclusions

In conclusion, the present findings provide robust support for the use of MBCT in the reduction of depression and suicidal ideation, and in the enhancement of sleep quality and self-esteem among women with a history of domestic violence. Given the severe and lasting psychological burden of such experiences, integrating MBCT into specialized intervention programs could play a critical role in fostering recovery, resilience, and

overall well-being in this vulnerable group.

Ethical Considerations

The studies involving human participants were reviewed and approved by the Ethics Committee.

Data Availability Statement

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

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Authors' contributions

N. Sh., Gh. N., A. D., and M. A. contributed to the study conception and design, material preparation, data collection, and analysis.

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Conflicts of Interest

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

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