

Cognitive Emotion Regulation and its Relationship with Depression, Generalized Anxiety Disorder, Eating Disorder and Somatic Symptom Disorder in a Sample of Adults

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Abstract

Objectives: This study examines the relationship between cognitive emotion regulation strategies and four psychological disorders (depression, generalized anxiety, eating disorders, and somatic symptom disorders) in Palestinian adults, filling a gap in research on mental health and illness from a culturally relevant perspective.

Methodology: A descriptive correlational design was used with 208 adults (43.3% males, 56.7% females) aged 20–50. Validated measures, including the Cognitive Emotion Regulation Questionnaire (CERQ) and the Psychopathology Scale (PDS), were administered via numerical questionnaires.

Findings: The study observed moderate levels of cognitive emotion regulation (mean = 3.28/5), with high use of coping strategies such as positive reappraisal (77.6%). Depression (66%) and anxiety (65%) showed high prevalence, while somatic symptoms had the lowest prevalence (51.7%). Maladaptive cognitive emotion regulation strategies (self-blame, rumination) were significantly associated with all psychological disorders ($r = 0.135-0.353$, $p \leq 0.05$). Females scored significantly higher on eating disorders, while males scored significantly higher on planning-focused regulation strategies.

Implications: These findings highlight the role of maladaptive cognitive emotion regulation in the exacerbation of psychological disorders, urging targeted interventions to promote adaptive regulation in crisis-affected populations.

Conclusions: The study emphasizes the need for culturally adapted mental health programs in Palestine, focusing on gender-specific curricula and adaptive emotion regulation training. **Keywords:** cognitive emotion regulation, psychological disorders, depression, generalized anxiety, eating disorders, somatic symptom disorder.

Key words

Cognitive Emotion Regulation, Psychological Disorders, Depression, Generalized Anxiety, Eating Disorders, Somatic Symptom Disorder.

Introduction

Cognitive emotion regulation (CER) is a rapidly expanding area of research due to its significant implications for both physical and psychological health (Naragon-Gainey et al., 2017; Southward & Cheavens, 2020). Conceptually, cognitive emotion regulation (CER) encompasses conscious cognitive processes through which individuals regulate emotions by intentionally processing emotionally laden information (Gross, 2015; Sahib et al., 2023). Cognitive emotion regulation (CER) strategies can be organized along a continuum from adaptive to maladaptive, and they significantly influence the emotional outcomes of distress-inducing experiences (Aldao et al., 2010). Major cognitive emotion regulation (CER) strategies include self-blame, acceptance, rumination, positive refocusing, refocusing on planning, and positive reappraisal (Garnefski et al., 2001). For cognitive emotion regulation (CER) strategies to effectively regulate emotions, individuals must possess the metacognitive capacity to consciously monitor their thoughts and feelings and to modulate their emotional responses according to situational demands (Khawar et al., 2023).

Cognitive emotion regulation involves both sequential and cyclical phases. The first phase is emotional identification, which entails awareness and accurate labeling of emotional states (Gratz & Roemer, 2004). Emotional acceptance allows individuals to experience emotions without judgmental analysis or avoidance (Hayes et al., 2012). Cognitive reappraisal refers to altering the meaning of a situation in order to change the emotional response by restructuring distorted cognition (Gross, 2015). Problem solving define the sources of distress and actively address the sources of distress through solution-focused engagement (D’Zurilla et al., 2004). Mindfulness cultivation entails maintaining a mindful focus on one’s self and engaging in nonjudgmental contemplation

without the necessity of acting on that awareness (Kabat-Zinn, 2003). The mastery of these competencies often requires formalized skills training (Berking & Whitley, 2014).

The research has shown that adaptive cognitive emotion regulation strategies not only reduce indicators of vulnerability, but also promote psychological well-being and increase positive cognition (Grewal & Salovey, 2005; Troy et al., 2018). Importantly, dysfunction in cognitive emotion regulation is a central feature of depression, anxiety, and other affective disorders, and it also constitutes a critical factor contributing to maladaptive behaviors in patients (Aldao et al., 2010; Berking & Wupperman, 2012). Moreover, evidence suggests that impairments in emotion suppression and expression core components of dysregulation can be observed even prior to the onset of a diagnosable disorder. (Panayiotou et al., 2017).

In summary, fostering cognitive emotion regulation skills represents an essential treatment objective, particularly within cognitive-behavioral and dialectical therapeutic approaches.

Cognitive Emotion Regulation strategies are conceptualized as conscious mechanisms that individuals employ to process emotional information and modulate emotional responses, particularly within negative affective contexts, and thus they are a key issue in the study of psychological adaptation and its outcomes. Recent empirical evidence has increasingly emphasized this perspective, revealing robust and specific associations between the utilization of such strategies and the onset and trajectory of diverse emotional problems. The application of maladaptive emotion regulation strategies such as suppression, rumination, and emotional avoidance exhibits a consistent relationship with symptoms of depression and anxiety, even during earlier developmental stages, including

adolescence and young adulthood (Domaradzka & Fajkowska, 2018; Joormann & Stanton, 2016; Zagaria et al., 2023).

It is also critical to acknowledge that regulatory anxiety defined as the apprehension regarding one's capacity to regulate emotions may serve as a predictive precursor for specific emotion regulation strategies. (Zagaria et al., 2023). In addition, inadequate management of one's cognitive-emotional responses to challenging situations has been linked to multiple disorders such as anxiety disorders, eating disorders, somatic symptom disorders, borderline personality disorder, disorders of substance use, and depressive disorders (Boemo et al., 2022; Davoodi et al., 2019; Gross & Muñoz, 1995; Igra, 2023; Kraiss et al., 2020; Menefee et al., 2022; Meneguzzo et al., 2022; Patel & Patel, 2019; Rodas et al., 2022).

Individuals with eating disorders frequently engage in avoidance and rumination, whereas those with somatic symptom disorders exhibit a propensity for maladaptive regulation, as measured by Davoodi's scales (Davoodi et al., 2019; Meneguzzo et al., 2022). Still, it is important to mention that the nature and magnitude of these associations may vary across individuals and specific disorders (Su et al., 2022). The emotion regulation model emphasizes critical individual differences, particularly in the management of negative emotions via adaptive strategies such as cognitive reappraisal, or alternatively through various maladaptive approaches. Such differences serve as a vital marker of an individual's ability to cope with stress, because inadequately configured or poorly regulated attempts to control emotional states may exacerbate psychological distress manifesting as heightened anxiety, increased physiological arousal, or other adverse outcomes thereby elevating susceptibility to psychological disorders and potentially impeding recovery or slowing down recovery (Boemo

et al., 2022).

Psychological disorders are defined as behavioral or mental patterns which cause distress or impair functioning (American Psychiatric Association, 2022). However, such disorders are a large scale issue, especially the most common ones depression and anxiety which are expected to affect one in eight people across the world (around 970 million people) (Barry et al., 2023; Newman et al., 2023; Phillips, 2020; Scholten et al., 2023; Tariq et al., 2022). These disorders emerge from an interplay of chronic psychological stress, traumatic experiences, genetic predispositions, social isolation, biochemical dysregulation, and physical illness (Howlett et al., 2022; Neria et al., 2009; Taschereau-Dumouchel et al., 2022). The study of emotion regulation processes continues to represent a critical avenue for clinical research and the development of effective interventions addressing mental health challenges.

Cognitive emotion regulation involves core processes in the development of psychological disorders. Patterns such as avoidance, rumination, and chronic suppression of emotions establish a complex central dynamic that influences mood, anxiety, and psychosomatic disorders. The importance of integrative research in this area lies in bridging neural, cognitive, and behavioral dimensions, demonstrating through longitudinal developmental studies how regulatory anxiety operates as a key predictive mechanism contributing to mental health deterioration across the lifespan. Further, contemporary evidence suggests that optimal recovery depends on reconstructing metacognitive frameworks, beginning with accurate emotional self-labeling, nonjudgmental acceptance, and the flexible reconstruction of meaning within adaptive psychological frameworks. Addressing the widespread prevalence of psychological disorders, recent interdisciplinary research endeavors to trans-

late these theoretical insights into practical intervention models. Such approaches reconfigure therapeutic pathways by employing clinically relevant tools that restore balance and equilibrium to emotional systems.

Previous Studies on Cognitive Emotion Regulation and Psychological Disorders, Alacha et al. (2025) investigated whether maladaptive cognitive emotion regulation strategies (CERS) predict learning effectiveness and whether ADHD symptoms moderate this relationship. As part of a larger project, a pilot study was conducted involving a sample of university students ($n = 4,183$; mean age = 19.24 years; 70.1% female) across eight universities. Results showed that students in the high ADHD group employed maladaptive CERS more frequently and exhibited poorer learning effectiveness in three key areas, particularly stress management and time constraints compared to the non-ADHD group. Furthermore, ADHD symptoms moderated the relationship between maladaptive CERS and chronic fatigue syndrome. Specifically, individuals with the highest levels of ADHD symptoms were less affected by maladaptive CERS.

Zagaria et al. (2023) participated in two exploratory cross-sectional studies aimed at clarifying the relationship between cognitive emotion regulation strategies and mental health indicators (i.e. symptoms of depression, anxiety and insomnia) in two independent samples of young adults ($n = 431$; Mage = 20.66 ± 2.21 ; females 70%, males 30%) and adolescents ($n = 27$; girls 44.6%, boys 55.4%). Participants were asked to complete a series of assessments, including the Cognitive Emotion Regulation Questionnaire, Insomnia Severity Index, Beck Depression Inventory-II, State-Trait Anxiety Inventory, and the Youth Self-Report. To examine the unique contributions of cognitive emotion regulation strategies to mental health indicators, multiple hierarchical regressions were conducted. In both the young adult and adoles-

cent samples, non-adaptive strategies (e.g., rumination, catastrophizing) were significantly associated with poorer mental health, indicating increased risk for psychopathology. In the young adult sample only, adaptive strategies (e.g., positive refocusing, positive reappraisal) were associated with better mental health indicators. These findings suggest that cognitive emotion regulation strategies likely function as risk factors for psychopathology, and that the development of emotion regulation strategies could serve as a beneficial therapeutic intervention. However, the differences between young adults and adolescents in the way which cognitive regulation strategies were associated with mental health indicators might reflect the empirical improvements in emotion regulation capabilities that occur with age.

Meneguzzo et al. (2022) examined emotional regulation in the context of eating disorders, with a particular focus on adaptive and maladaptive coping strategies within an inpatient cohort. The study also evaluated the effectiveness of a specialized treatment program that emphasized an intensive, structured, multidisciplinary framework of cognitive behavioral therapy (CBT) and the flexible application of third-wave approaches in a personalized manner. The cohort consisted of 67 patients with eating disorders (28 with anorexia nervosa, 28 with bulimia nervosa, and 11 with binge-eating disorder), all assessed for emotional regulation difficulties, alexithymia, and dissociative symptoms upon admission to the specialist ward. The study reported statistically significant improvements in emotional regulation difficulties and dissociative symptoms at discharge.

Livingstone and Isaacowitz (2021) investigated age-related differences in cognitive emotion regulation strategies using a correlational descriptive design. Their sample consisted of 149 middle-aged and older adults. Results indicated that middle-aged

adults demonstrated greater use of adaptive cognitive emotion regulation strategies compared to older adults, highlighting potential age-related declines in regulatory flexibility.

Based on a sample of participants diagnosed with depression, Huh et al., (2017) recommended the use of path analysis models when developing models of cognitive emotion regulation as a mediator between childhood trauma and psychological symptoms in adulthood. In their correlational descriptive study, a sample of 585 depressed adults was recruited. The authors collected the necessary data using the Beck Depression Inventory, State and Trait Anxiety Inventory, Childhood Trauma Questionnaire, and Cognitive Emotion Regulation Questionnaire. They found out that childhood trauma predicted current levels of depression and anxiety indirectly through maladaptive cognitive emotion regulation strategies. Overall, these findings demonstrate the potentially important mediating role of maladaptive cognitive emotion regulation strategies in explaining the long-term effects of childhood trauma.

Balzarotti et al., (2016) conducted a cross-sectional study with 470 adults to examine the associations between nine cognitive emotion regulation strategies and psychological well-being. The results demonstrated that positive reappraisal and refocusing on planning were positively associated with both subjective and psychological well-being, whereas rumination, catastrophizing, and self-blame were linked to poorer mental health. Strategies such as positive refocusing, perspective-taking, and acceptance showed negligible significant correlations.

Haynos et al., (2015) conducted a correlational descriptive study with 59 underweight individuals to examine how emotion regulation difficulties, anxiety, and eating disorder symptom severity were

correlated and interacted as constructs. The study employed questionnaires and interviews to assess emotion regulation difficulties, anxiety, eating disorder symptom severity, and clinically related impairment. The authors found that eating disorder symptoms and clinical impairment from eating disorders were meaningfully correlated with emotion regulation difficulties only when anxiety levels were low. They also suggested that anxiety was associated with eating disorder symptoms and clinical impairment from eating disorders when emotion regulation difficulties were not high, indicating an interactive relationship between these variables.

Synthesis and Novelty of the Current Study the reviewed studies informed the theoretical framework and methodological design of the present research. This study provides novel insights by focusing on an Arab population, specifically Palestinians, and uniquely examining the interplay between cognitive emotion regulation and four psychological disorders within a single investigation. To the researcher's knowledge, this is among the first studies in the Arab region to simultaneously analyze these five variables, thereby addressing a significant gap in culturally specific and comprehensive mental health research.

Research Problem

Human behavior is a complex phenomenon that can be influenced both directly and indirectly by one's emotions and thoughts. Moreover, emotions are believed to affect psychological and physical health, as well as social interactions. Thoughts can be classified as cognitive mental processes, encompassing our notions, perspectives, and beliefs about people, life, and ourselves in general, whereas emotions are defined as internal feelings arising from specific situations. Proper management of these thoughts and emotions improves mental health (Malik & Perveen, 2023). Conversely, emotional health problems may emerge

due to dysfunctions in emotion regulation. There is substantial evidence documenting the significance of cognitive-emotional regulation in every individual's life (Ludwig et al., 2019) and how such regulation can help balance emotions and rational thinking during challenging situations (Lasa-Aristu et al., 2019). Individuals lacking proper regulation often experience cognitive-emotional deficits, including angry outbursts, anxiety, and depression (Jones, 2023).

The multiple crises affecting Palestinian society have resulted in a rise in psychological disorders. According to the Youth Bloc for Supporting Rights and Justice in Public Services, which conducted a study in 2022, 50% of Palestinians experience depression, with figures in the Gaza Strip reaching a remarkable 71%. This situation underscores the need for urgent interventions targeting coping skills, alongside mental health and emotional regulation strategies, to enhance psychological resilience, particularly in a society grappling with chronic mental illness. Accordingly, this correlational study aims to address the following research:

Accordingly, this correlational study aims to address the following research:

1. What are the cognitive-emotional regulation levels alongside the prevalence of depression, generalized anxiety, eating disorders, and somatic symptom disorders in adults?

2. Is there a relationship between cognitive-emotional regulation and depression, generalized anxiety, eating disorders, and somatic symptom disorders among adults?

3. Are there statistically significant differences in cognitive-emotional regulation, depression, generalized anxiety, eating disorders, and somatic symptom disorders among adults attributable to gender?

Objectives:

1. Assess the degree of cognitive-emotional regulation and scope of depression, generalized anxiety, eating disorders, and somatic symptom disorders in adults.

2. Analyze the cognitive-emotional regulation concerning the psychological disorders mentioned above.

3. Analyze the differences between male and female subjects in cognitive-emotional regulation and psychological disorders.

Theoretical and Practical Significance: This research adds to the theoretical understanding of the cognitive and emotional aspects of regulation in relation to various psychological disorders. It helps clarify the relationships between emotion regulation strategies and conditions such as depression, generalized anxiety, eating disorders, and somatic disorders, thereby enriching the discourse on mental health in populations affected by crises. **Practical Significance:** Based on the findings of this research, other researchers and clinical practitioners will be better informed, enabling them to design specific training programs and counseling frameworks aimed at enhancing cognitive-emotional regulation and addressing psychological disorders.

Study Limitations

1. **Human Boundaries:** The sample was limited to adult participants.

2. **Spatial Boundaries:** Conducted within the southern governorates of Palestine.

3. **Temporal Boundaries:** Implemented during the 2023-2024 academic year.

4. Conceptual Boundaries: The study was limited to the constructs within the study's definitional reliance framework. Academic Translation: Conceptual and Operational Definitions of Study Variables.

Cognitive Emotion Regulation (CER): Conceptually, CER represents conscious mental methods that individuals apply to deal with emotionally laden information (Garnefski et al., 2002). It is operationally defined as the participants' score in the Cognitive Emotion Regulation Questionnaire (CERQ).

Depressive Disorder: In common with other mood disorders, depressive disorder is a mood disorder with a chronic and sustained sadness and loss of interest in activities that used to be enjoyed. Depression results in a variety of emotional and physical disabilities (American Psychiatric Association, 2022). It is, operationally, the score that people get on the Depression Scale.

Generalized Anxiety Disorder (GAD): In this context disordered eating represents serious mental disorders affecting health and physical and psychological well-being, characterized by pathological eating patterns and features with negative effects on health (APA, 2022). Operationally, it is represented by the score which the participants achieve on the Eating Disorder Scale.

Eating Disorder: Conceptually, eating disorders are serious mental health conditions that impact physical and psychological well-being, linked to abnormal eating behaviors with detrimental health consequences (APA, 2022). Operationally, it is defined as the score obtained by participants on the Eating Disorder Scale.

Somatic Symptom Disorder (SSD): SSF is a psychiatric problem in which persons have one or more bodily symptoms (ie, pain, weakness, or shortness of

breath) that lead to significant distress or impairment, but that cannot be fully explained by the presence of an underlying medical condition (APA, 2022). In operational terms, it is the ratings on the Somatic Symptom Disorder Scale by subjects.

Study Design and Procedures Methodology:

To achieve the study's objectives, the purposes of the research and the items used for the research question required a descriptive correlational method to serve the intended objectives and complete the research questions.

Population and Sample

1. Pilot Sample: The pilot sample consisted of 30 adults from the Gaza Governorates. The sample was separated from the main study and was utilized to see the validity of the research scales. The researchers were able to evaluate the psychometric properties of the research scales and ensure that the tools were applicable for the present study by determining the reliability and validity of the scales.

2. Sample of the major study: The main study consisted of 208 adults, with ages range from 20 to 50. There were 90 males (43.3%) and 118 females (56.7%). Due to the challenges that the researchers faced in gathering data, participants were selected using convenience sampling. Many participants used the Google Forms online questionnaire that the researcher created, and the online questionnaire was used and sent through online communication.

The use of Google Forms in Gaza introduced potential sampling bias, as participation was limited to individuals with internet access and sufficient technological literacy. This may have excluded marginalized groups such as the elderly and low-income populations, reducing the representativeness of the sample. Readers should therefore interpret the results with

caution.

Table (1) shows a complete demographic of the sample population corresponding to gender and age.

Table (1): Distribution of the Sample by Gender and Age.

Variable	Category	Frequency	Percentage (%)
Gender	Male	90	43.3%
	Female	118	56.7%
	Total	208	100 %
Age	20–30	60	28%
	31–40	64	30%
	41–50	84	40.3%
	Total	208	100%

The methodological implications of using in studies that utilized Google Forms in the Gaza Strip are fundamental. A sample $n = 208$ adults, doesn't represent the target population (age group 20-50 years), according to Jayasuriya et al. (2021) due to self-selection bias by restricting sampling participants to digital access and tech capability. This methodological bias excludes socially important strata of society, such as elderly individuals who have limited access to technology, individuals from low-income backgrounds, and those from socially marginalized areas while it over-represents segments that are educated and electronically active. In addition to the demographic differences of representation, such as the percent of female 56.7% versus male 43.3%, also demonstrates the social characteristics of the samples don't mirror the actual population group and limits evidence of the results to the sector level. Therefore, it is recommended that readers or interested people take care in making sense of the results, share and disclose the limitations as the basis of developing future studies that try to address gaps in representation of the local community.

Study Instruments

In order to fulfill the objectives of the study, three scales were used:

1. 1. Cognitive Emotion Regulation Questionnaire (CERQ): The Cognitive Emotion Regulation Questionnaire developed by Garnefski et al. (2002) was used. The original included 24 items and six domains; three negative cognitive emotion regulation domains (self-blame, acceptance, rumination) and three positive cognitive emotion regulation domains (positive refocusing, refocusing on planning, positive reappraisal).

2. 2. Psychological Disorder Scale (PDS): The Psychological Disorder Scale was used based on the work of AlHadi et al. (2017). The psychological disorder scale initially consisted of 38 items across five domains: depression, generalized anxiety, eating disorder, somatic symptoms, and alcohol use. However, the alcohol use domain (5 items) was eliminated, resulting in a scale of 33 items (four disorders).

Face Validity of the Scales

To verify the face validity (expert validity) of the three scales, the preliminary versions were reviewed by seven specialists holding PhDs in psychological counseling, educational guidance, and psychology. An 80% agreement threshold was set as the minimum criterion for item retention. Based on expert feedback, adjustments were made to item phrasing, and the final versions were prepared for pilot testing. Modifications included:

- CERQ: All 24 items were retained after rephrasing.
- PDS: The alcohol use domain (5 items) was removed; based on the cultural specificity of the Gazan society, which is free of alcohol consumption in line with its religious and social principles, scientific necessity necessitated the deletion of this domain from

the psychological scale. Including items that do not exist in the local context threatens the reliability of the instrument and confuses respondents. Furthermore, introducing a religiously taboo topic entails ethical sensitivity that may undermine participants' confidence and bias the results. Furthermore, measuring a non-existent phenomenon deprives the scale of its contextual validity and reduces the clinical significance of the results in the target environment. This necessitated modification to ensure the accuracy of the psychological scale and its suitability to the community's specificity without compromising the principles of scientific construction. reducing the total to 33 items.

Psychometric Properties of the Scales

The scales were pilot-tested on 30 adults from Gaza Governorates (excluded from the main sample) to assess validity and reliability.

1. Construct Validity

Pearson's correlation coefficients were calculated to evaluate item-domain and item-total score relationships. Correlation strength was classified as follows (Cohen et al., 2009):

- Strong: ± 0.50 to ± 1.00
- Moderate: ± 0.30 to ± 0.49
- Weak: $< \pm 0.30$

Results:

- CERQ: Item-total correlations ranged from 0.31 to 0.89, except for Item 1 (0.22), which was excluded, reducing the scale to 23 items.
- PDS: Item-total correlations ranged from 0.38 to 0.92, except for Item 7 (generalized anxiety domain; 0.17), which was excluded, resulting in 32 items.

2. Reliability

Internal consistency was assessed using Cronbach's alpha (Gliem & Gliem, 2003). Values ≥ 0.70 indicate

acceptable reliability.

Table (2): Reliability Coefficients (Cronbach's Alpha) for the Scales.

Scale	Domain	Items	Cronbach's α
CERQ	Self-Blame	3	0.843
	Acceptance	4	0.907
	Rumination	4	0.852
	Positive Refocusing	4	0.970
	Refocusing on Planning	4	0.905
	Positive Reappraisal	4	0.905
CERQ Total		23	0.896
PDS	Depression	10	0.920
	Generalized Anxiety	9	0.868
	Eating Disorders	7	0.841
	Somatic Symptoms	7	0.869
PDS Total		32	-

Interpretation:

- CERQ: High reliability ($\alpha = 0.843-0.970$; total $\alpha = 0.896$).
- PDS: High reliability ($\alpha = 0.841-0.920$).

Correction of Study Scales

First: Cognitive Emotional Regulation Scale

The Cognitive-Emotional Regulation Scale, in its final validated form, consists of 23 items divided into six domains. It includes 11 negative items distributed across three domains and 12 positive items across three domains. Each item is accompanied by five response options: Always, Often, Sometimes, Rarely, Never. Positive items are scored as 5-4-3-2-1, while negative items are reverse-scored as 1-2-3-4-5. The total score ranges from 23 to 115, with higher scores indicating positive cognitive emotional regulation and lower scores reflecting negative cognitive-emotional regulation.

Second: Psychological Disorders Scale

The Psychological Disorders Scale, in its final validated form, comprises 33 items, a mix of positively and negatively phrased statements. Each item includes five response options: Always, Often, Some-

times, Rarely, Never. Positive items are scored 4-3-2-1-0, while negative items are reverse-scored. The scale measures four specific disorders as follows:

1. Eating Disorder: 7 items, with scores ranging from 0–28 (severe disorder to no disorder).
2. Depression: 9 items, with scores ranging from 0–32 (severe disorder to no disorder).
3. Generalized Anxiety Disorder: 9 items, with scores ranging from 0–32 (severe disorder to no disorder).
4. Somatic Symptom Disorder: 7 items, with scores ranging from 0–28 (severe disorder to no disorder).

Scores are classified into three levels: High, Medium, and Low, based on the cutoff percentages in Table 3.

Table (3): Cutoff Scores for Classifying Cognitive-Emotional Regulation and Psychological Disorders.

Level	Percentage Range
Low	≤ 46.7 %
Medium	46.8% – 73.5%
High	73.6% – 100%

Scores were classified into three levels—Low (≤46.7%), Medium (46.8%–73.5%), and High (≥ 73.6%)—based on the percentage of the theoretical maximum score. This method allowed for standardization across scales of different lengths and facilitated meaningful comparisons. In order to interpret the results of the five-point Likert scale, the study relied on the relative conversion of raw scores to percentage values (% of the theoretical maximum of the scale) to ensure standard equivalence across scales of different lengths (Ali et al., 2021), enable comparison of cutoff points to standardized criteria (Garnefski & Kraaij, 2007), and address non-normal distribution bias by converting the data to a continuous percentage range (0–100%) suitable for parametric analysis (Jermann et al., 2006), using the equation:

(Total raw scores / Theoretical maximum of the

scale) × 100

Study Design and Variables

The study included the following variables:

- Independent Variable: Cognitive-Emotional Regulation.
- Dependent Variables: Eating Disorder, Depression, Generalized Anxiety Disorder, and Somatic Symptom Disorder.
- Demographic Variable: Gender.

Study Implementation Procedures

The study was conducted according to the following steps:

1. Literature Review: Collecting information from books, articles, reports, theses, and other sources to establish the theoretical framework.
2. Population and Sampling: Defining the study population and selecting the sample.
3. Tool Development: Designing study instruments based on educational literature in the field.
4. Expert Validation: Reviewing study tools by experts to ensure validity.
5. Pilot Testing: Administering the tools to a pilot sample of 30 adults (excluded from the main sample) to assess validity and reliability.
6. Main Data Collection: Applying the finalized tools to the main sample after obtaining participants' consent. Participants were assured that responses would remain confidential and used solely for research purposes.
7. Data Analysis: Entering data into SPSS (Version 28) for statistical analysis.
8. Interpretation: Discussing results in light of theoretical frameworks and previous studies, followed by recommendations.

Statistical Analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS) with the following

methods:

1. Descriptive Statistics: Means, standard deviations, and percentages.
2. Reliability: Cronbach's Alpha coefficient.
3. Item-Total Correlation: Pearson Correlation to examine relationships between items and their domains.
4. Group Differences: Independent Samples t-test to assess gender-based differences.
5. Variable Relationships: Pearson Correlation to explore associations between cognitive-emotional regulation and psychological disorders.

Results

Answering the First Question: What is the level of cognitive-emotional regulation and the prevalence of depression, generalized anxiety disorder, eating disorders, and somatic symptom disorder among a sample of adults?

To assess cognitive-emotional regulation in the adult sample, means and standard deviations were calculated, as illustrated in Table (4).

Table (4) shows an overall level of cognitive-emotional regulation at a moderate level (Mean = 3.28). The sub dimensions of self-blame, acceptance, rumination, and positive refocusing achieved moderately rated scores (2.90, 2.80, 2.94, and 3.33, respectively). In contrast, refocus on planning (3.67) and positive reappraisal (3.88) achieved high ratings, with positive reappraisal first (positive direction). Negative dimensions (rumination, self-blame, acceptance) estimated 4th, 5th, and 6th. Positive dimensions achieved high to moderate levels, and negative dimensions were moderate. For psychiatric disorders, means and standard deviations were calculated, as shown in Table 5.

Table 5 indicates moderate prevalence of depression (Mean = 2.67, 66%), generalized anxiety (Mean = 2.62, 65%), and eating disorders (Mean = 2.32,

58%), while prevalence for somatic symptom disorder (Mean = 2.07, 51.7%) was rated as low. Depression was most prevalent, followed by anxiety and eating disorders.

Answering the Second Question: Is there a relationship between cognitive-emotional regulation and depression, generalized anxiety, eating disorders, and somatic symptom disorder in adults?

Pearson correlation coefficients were calculated between cognitive-emotional regulation dimensions and psychiatric disorders (Table 6).

Based on the results of Table 6, the correlations show strong positive relationships between negative cognitive-emotional regulation strategies (self-blame and rumination) and all psychological disorders studied, with the highest correlation being recorded with somatic symptoms. In contrast, positive regulation strategies (positive refocusing, planning refocusing, and positive reappraisal) showed no statistically significant association with any of the disorders. One possible explanation for the lack of significant associations between positive regulation strategies and psychological disorders is the contextual severity of the Gaza setting. Under conditions of chronic conflict and instability, adaptive strategies such as positive reappraisal may lose their protective effect or be overwhelmed by persistent stressors. Finally, although there was a statistically significant association between the total cognitive-emotional regulation score and all disorders, the strength of these associations remained relatively weak.

Answering the Third Question: Are there statistically significant gender differences in cognitive-emotional regulation and psychiatric disorders among adults?

Independent Samples t-tests were conducted (Table 7).

Table (4): Means, Standard Deviations, and Rankings of Cognitive-Emotional Regulation Dimensions in the Adult Sample.

Dimension	N	Mean	SD	Rating	Rank	Direction	Percentage
Self-blame	208	2.90	0.851	Moderate	5	Negative	58%
Acceptance	208	2.80	0.998	Moderate	6	Negative	56%
Rumination	208	2.94	0.841	Moderate	4	Negative	58.8%
Positive Refocusing	208	3.33	0.823	Moderate	3	Positive	66.6%
Refocus on Planning	208	3.67	0.989	High	2	Positive	73.4%
Positive Reappraisal	208	3.88	1.06	High	1	Positive	77.6%
Total Cognitive-Emotional Regulation	208	3.28	0.692	Moderate	–	–	65.6%

Table (5): Means, Standard Deviations, and Rankings of Psychiatric Disorders in the Adult Sample.

Disorder	N	Mean	SD	Rating	Rank	Direction	Percentage
Eating Disorder	208	2.32	1.134	Moderate	3	Negative	58%
Depression	208	2.67	1.228	Moderate	1	Negative	66%
Generalized Anxiety	208	2.62	1.122	Moderate	2	Negative	65%
Somatic Symptom Disorder	208	2.07	0.99591	Low	4	Negative	51.7%

Table (6): Pearson Correlation Matrix between Cognitive-Emotional Regulation and Psychiatric Disorders.

Variable	Depression	Generalized Anxiety	Eating Disorder	Somatic Symptoms
Self-blame	0.217**	0.167**	0.135**	0.353**
Acceptance	0.237**	0.125**	0.269**	0.148**
Rumination	0.216**	0.191**	0.127**	0.349**
Positive Refocusing	0.246	0.187	0.124	0.179
Refocus on Planning	0.006	0.003	0.114	0.098
Positive Reappraisal	0.122	0.005	0.106	0.045
Total Regulation	0.153**	0.172**	0.150**	0.197**

Table (7): T-Test Results for Gender Differences in Cognitive-Emotional Regulation and Psychiatric Disorders.

Dimension	Gender	N	Mean	SD	t-Value	p-Value
Refocus on Planning	Male	90	3.68	1.09	1.551	0.022*
	Female	118	3.67	0.900		
Eating Disorder	Male	90	2.13	1.123	0.462	0.011*
	Female	118	2.47	1.125		

The analysis results revealed significant gender differences in the domains of cognitive-emotional regulation and psychological disorders. Males scored higher on the refocusing planning strategy than females, while females showed higher levels of eating disorder symptoms. No other dimensions showed statistically significant differences between the two groups at the selected significance level.

Discussion

The study's findings indicated that adults in the sample exhibited a moderate level of cognitive-emotional regulation. This suggests that the percentage should be elevated rather than considered acceptable. The findings of Zagaria et al. (2023) underscore the detrimental effects of insufficient cognitive-emotional regulation on mental health, particularly given that the age group of the study sample necessitates higher levels of such regulation, as demonstrated by Livingstone and Isaacowitz (2021). Consequently, interventions aimed at enhancing cognitive-emotional regulation strategies are essential, as these strategies play a crucial role in coping with difficult environmental circumstances including political, economic, social crises, wars, and the resulting destruction.

The current study also revealed moderate levels of depression among the participants, consistent with the findings of a local study by Qaoud et al. (2022). This represents a serious concern, as depression is a significant disorder that may lead to suicidal behavior if timely psychological intervention is not provided. The underlying causes of depression may be environmental or linked to adverse childhood experiences, consistent with Huh et al. (2017). Moreover, the results indicated high levels of generalized anxiety, likely resulting from deficits in cognitive-emotional regulation over time. Several factors may contribute to this including psychological, occupational, and security instability, especially given Gaza's status as a

high-conflict zone. This instability can sometimes result in anxiety without clear explanation. The findings are aligned with Al-Dreimli and Al-Jabouri (2019).

Additionally, the study observed moderate levels of eating disorders among the sample, consistent with Haynos et al. (2015), who also identified a relationship between emotion regulation difficulties and eating disorder symptoms, particularly in contexts of low anxiety. The relatively low prevalence of somatic symptom disorder in the sample aligns with previous research conducted in similar contexts.

In addressing the second research question, the study demonstrated a statistically significant positive correlation between cognitive-emotional regulation and depression, generalized anxiety disorder, eating disorders, and somatic symptom disorder in adults. These results are consistent with previous studies by Zagaria et al. (2023), Meneguzzo et al. (2022), Huh et al. (2017), Balzarotti et al. (2016), and Haynos et al. (2015).

The researcher concludes that the average level of cognitive-emotional regulation among adults in Gaza, although adaptive in response to the depletion of psychological resources in a conflict environment, constitutes a risk factor that increases with age. This threat manifests through multiple pathways. On one hand, poor emotional regulation fuels a vicious cycle of depression by enhancing rumination and denial mechanisms, transforming mild depression associated with childhood trauma into more severe forms. On the other hand, generalized anxiety results from the interaction of an unstable environment including job and psychological insecurity with the internal turmoil caused by dysregulation, creating fertile ground for unexplained anxiety. The observed discrepancy between eating disorders and somatic disorders can be interpreted through the survival priorities theory:

cultural pressures regarding body image, particularly among females, translated into disordered eating behaviors, whereas somatic symptoms are repressed to prioritize basic survival in emergency contexts.

Regarding gender differences, males are more likely to use refocusing strategies for planning, reflecting societal pressures toward practical solutions. In contrast, the increase in eating disorders among females is linked to mechanisms that convert psychological stress into somatic symptoms.

These findings must be understood within the Palestinian context, where chronic political, economic, and security pressures may exacerbate maladaptive regulation patterns and weaken the efficacy of adaptive coping mechanisms. They align with theoretical frameworks such as the vicious cycle model, which links poor emotional regulation to the exacerbation of psychological disorders, wherein depression is reinforced through mechanisms of self-blame and persistent rumination. Moreover, these results highlight the unique psychopathological transformations within the Palestinian context, as chronic collective stressors, including the ongoing blockade and recurrent war experiences, translated into individual psychological disorders through the depletion of coping resources.

The current study recommends

1. Emphasize the development of development programs focused on raising levels of cognitive emotional regulation in children and adolescents.

2. Inform counseling and psychotherapy centers about intensifying therapeutic programs to reduce psychological disorders in adults.

The study also presents research proposals:

1. Conduct the current study on other age groups, such as adolescents and the elderly.

2. Address the cognitive-emotional regulation variable in conjunction with other disorders, such as trauma, post-traumatic stress disorder, transgenerational trauma, and sleep disturbance.

3. Study a counseling program based on cognitive theories to raise levels of cognitive-emotional regulation.

Institutional Review Board (IRB) Approval:

A comprehensive research protocol was submitted to an Institutional Ethics Review Board (IRB) an independent committee charged with protecting the rights and welfare of research participants. The protocol included a detailed methodology, research tools (such as the Cognitive Evaluation and Reappraisal Questionnaire (CERQ) and the Post-Event Stress Scale (PDS), informed consent procedures, data management plans, and risk-benefit analysis. The committee carefully reviewed the proposal, focusing on: scientific method validity and ensuring consistency of research design; assessment of potential psychological risks (such as distress resulting from sensitive questions) and mitigation strategies (such as providing support resources and ensuring voluntary participation); analysis of potential benefits and risks to participants; data confidentiality and anonymity (including storing data in password-protected files and encrypted storage spaces, not collecting personally identifiable information, and using secure Google Forms); clarity of the informed consent process; consideration of participants' vulnerability in the Gaza context; and ensuring additional safeguards to protect those who may experience psychological distress. The research obtained formal written approval from the committee prior to any contact with participants or data collection, and the researcher retained documentation of this approval.

Informed Consent Process:

Participation in the study was completely voluntary and all potential participants received the detailed digital informed consent prior to gain access to the survey. The informed consent was clearly written in Arabic and included the research aims, research procedures, expected time commitment, possible risks (e.g. temporary discomfort recalling difficult experiences), possible benefits (e.g. contributing to understanding in regards to mental health needs), confidentiality, the anonymity of participants. The participation was completely voluntary, and participants could withdraw at any time without penalty; the contact information of the researcher and Institutional Review Board (IRB) if they had questions, encountered potential harm, or wanted to make a complaint; and how to access local mental health support if they experienced distress from participating. The informed consent was considered complete once participants consented electronically at the screen where they selected the, "I agree" option completing the informed consent process, and completed the survey after the informed consent.

Data Confidentiality:

Data were managed with the utmost confidentiality. None of the personal information collected (e.g., names, identification numbers, full addresses) could be traced or linked to survey responses. Data collected via the Google Forms tool were securely stored on password-protected servers, accessible only to the principal investigator. The dataset downloaded for analysis consisted exclusively of anonymized participant information. Researchers stored these datasets on encrypted devices. Published results will present only aggregated data, ensuring that individual responses cannot be identified in any publications or presentations. Data will be securely retained for the legislatively required period following the study's completion and subsequently disposed of in accordance with regulations.

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The researchers declare and undertake that there is no conflict of interest with any person or institution. This research has not been previously published in any way, whether written, read, published, visual or audio.

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