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Effectiveness of emotion focused therapy on sexual victims of romantic relationships: A single case study

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Abstract

Introduction: Emotion-Focused Therapy is a short-term intervention which can target a constellation of disturbances characterized as complex PTSD stemming from sexual abuse. The aim of this study was to study the effectiveness of emotion-focused therapy for sexual victims of romantic relationships.

Materials and Methods: The clinical trial study was done by a single case method and a multiple baseline design. Three subjects (three women) were selected through purposive sampling. Emotion-focused therapy was conducted in 12 weekly sessions during years 2011-12 at the University Counseling Center and follow-up sessions were held three months after the treatment. Subjects completed Posttraumatic Stress Disorder Scale, Rosenberg Self-esteem, Beck Depression Inventory-II, Beck Anxiety Inventory, and Rumination questionnaires before treatment (at baseline), during sessions, and at three month follow-up. They also completed Post-traumatic Stress and General Health Questionnaire (GHQ-28) pre-treatment, before entry into the study. Clinical significance and recovery percentage were used for data analysis.

Results: The results of study showed that emotion-focused therapy led to a significant improvement in PTSD, depression, anxiety, and rumination symptoms and increasing self-esteem in participants. Moreover, these results were maintained in a three-month follow-up in all the targets.

Conclusion: It seems that emotion-focused therapy is effective in modulating clinical symptoms in sexual victims of romantic relationships and improves their self-esteem.

Keywords: Emotion, Post traumatic stress disorder, Romantic, Sexual, Victim

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Introduction

In each period of life, a person involves in special relationship with others that can promote his individual and social health or damage it. Finding a partner is an important event in adulthood that has a profound effect on the self-concept and mental health. The relationship before marriage between boys and girls has always been as a social problem. Home and school authorities constantly faced with the problem of how boys and girls kept apart until the right time to get married. However, these relationships are formed. The society and the family refuses to accept these relationships and if in these cases, sex is also to be added, the victim suffered serious problems and mental health problems and escape from the house will follow. In this way the girls much more than boys, suffer from psychological and social trauma, and sometimes physical and health (1).

Almost half of college-age women, who are victims of non-consensual sex, didn't know it as a rape. Most of the girls in romantic relationship have sex for fear of rupture. These women are called "unwary victims", because they can't understand they were raped. Koss and Boeschen showed in research 57 percent of rapes has been made on the appointment

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(quoted out of 2). Girls who are in relationship, because they have still romantic relationship with the other person and in their view the prospect of this relationship is marriage so they don't show symptoms of Post-traumatic stress disorder (PTSD) during sexual relationship and days later But severe psychological symptoms are caused after breaking of relationship (1). At least one-third of them will suffer from PTSD. According to the study, 9% of women who had been sexually abused were threatened to cut the relationship by the student of the opposite gender (3). Symptoms of such a situation go beyond those of Post-traumatic stress disorder (PTSD) in DSM-IV to include a combination of Axis I and Axis II disorders as well as interpersonal difficulties and problems with affect regulations (e.g. over control or under-regulation) (4).

Victims get into troubles at least in two personal and social dimensions. In personal dimension, the victim is aware of her emotional problems and asks for help. She feels sick or unhappy, physical problems, mental confusion, scattered thinking and anxiety. She avoids profound emotional bonds with others and is secluded, crabbed and restless. Socially, is naive and incompetent, feeling alien to the people and considering her as a damaged merchandise that is banished of community and can't go ahead. The problem is doubled by parents and community's reaction. In these cases, the fathers' reaction to daughters is detention or deportation of house. The look in Silverman's mind (quoted out of 5) is full of hatred and blame. Modifying this attitude needs to the fundamental proceedings of family education and provide specialized treatment and counseling centers for these people.

Therefore, performing psychological interventions to identify emotion, evoking it, reducing affliction, reminding memories, rumination, and depression and in general, the clinical syndrome of clients is what psychologists, psychiatrists, social workers, doctors and legal society are attracted to (1). To date, the effectiveness of some treatments for disorders related to trauma and sexual abuse is approved. However, there is no evidence to treat specific symptoms of sexual abuse and improve mental function (6). Constellation of disorders stemming from sexual abuse of girls in romantic relationship requires a comprehensive treatment approach which targets identifying the specific symptoms and also problems like under-regulation affections, over control and personal problems.

Emotional evoking at first was proposed by Frank in 1963 and after that, the importance of romantic system on understanding and changing experience and human behavior was known. In many treatment approaches three factors are important in the process of psychotherapy change: emotional awareness, emotional arousal and emotional rehabilitation. Hence, increase emotional processing in cognitive approaches, the fear arousal by imagination stimulant in behavioral approaches, emotional insight in psychodynamic approaches, increasing the experience depth in experimental approaches and transference feelings in interaction approaches, are all aspects of dealing with emotions that are considered important in each approach. It's possible to intervene about emotion in different ways during treatment (7, 8). Although cognitive-behavioral therapy focuses on the importance of cognitive in activation and persistence of negative mood (9) and it has strong empirical support, PTSD symptoms in many patients relapse after treatment. For this reason, treatment approaches should be extended to be able to modify the symptoms (10). So we chose cognitive-behavioral therapy based on emotion-focused therapy (EFT), because emotion-focused therapy emphasize on the role of emotions in function and change (11).

Emotion-Focused Therapy is a short-term intervention (12). According to current emotions theory (13,14) emotions system has the role of organizing experience of reality, sense of self and orientation towards others. Also romantic problems can be treated just through accessing the emotions and romantic sense. EFT is performed according to three strategies related to change: 1. Access and modifying maladaptive romantic sense associated with fear and anxiety and shame experiences, 2.Access the adaptive emotions that are already inhibited, such as anger and sadness, so that relevant information with these emotions integrated with current semantic systems and 3. Providing a corrective experience with the therapist (4, 15). Important goal of this approach is helping people to clarify their feelings and needs, because in this way, people get more acceptance of what they have emotional significance for them (16). One important dimension of treatment is awareness of emotional schemes that conducts experience and action. Here emotion isn't meant of arousal or seething and as a destructive factor of cognitive or behavior. Although emotion is perceived negative culturally and a "very emotional" person is regarded as a needy person to control emotions, in this way emotion is considered with positive outlook because it's our message to ourselves. Emotions make us aware of our needs

and provoke effective action (7).

EFT helps patients in regulating affection (cognitive, romantic, behavioral strategies that are used for increasing adaptive emotions and reducing maladaptive emotions) and modifying emotional memories. The aim is changing self-organization through more utilization of emotion, affection regulation and modifying emotional memories. These goals are accomplished by the combination of abreaction (Corrective emotional experience) and selection (Free yourself or sense of commitment to a new way of being) (17,18).

EFT is a semi-structured treatment and based on resolution of interpersonal dissatisfaction about trauma (19). Treatment emphasize on explicit dominance to over control affections, so that clients can express their romantic and resolve issues. In EFT, the quality of the therapeutic relationship changes the sense of self and her expectations of others. Sense of safety of treatment allows his to experience and express painful emotions. Narrative of the traumatic experience, in turn leads to steer away from this experiences and client learn that he can tolerate and regulate his severe affections through comforting interactions with the therapist (20). This is consistent with research findings that support the effectiveness of PTSD exposure techniques including sexual abuse (6,21,22). Studies (4,23,24) showed that EFT follows by significant advances in different areas for different types of abuse.

The main aim of this study is to study the effectiveness of emotion-focused therapy for sexual victims of romantic relationships. Emotion-focused approach was chosen because it gives more consideration to affections and emotional processing.

Materials and Methods

The research registered on the site of clinical trials of Iran with IRCT209299789N2 code, within quasi experimental single case method using the multiple baseline design was studied. Experimental single case schemes have many positive features, such as proportional control of treatment situation, ongoing assessment and baseline formation (25). The purposive sampling method was used in this research. After the notification for treatment of romantic failure in Tabriz universities in 2011-2012,clients visited , but it became clear after the interview that they had sexual intercourse with person of interest in their failed romantic relationship. It had been suggested by boy. If girl refused, it would lead to cut the relationship. Therefore, girls had chosen sex to solve the problem. However, the boys cut off their relationship after sex. In fact, after the break, the girls had developed post-traumatic stress disorder syndrome and had experienced the feeling of being a victim. Specific samples (3 patients) were selected, in order to adhere to ethical considerations was written consent from clients in return for psychological services, the results be reported anonymously. Also clients had full authority to sign the consent. After clinical interview and mental health GHQ-28 and scale PTSD, three subjects of ten with lower mental health and had at least two symptoms of re-experience, avoidance, and or hyper arousal about the PTSD disorder syndrome, was selected. To determine that people did not have a personality disorder, Millon Clinical Multiaxial Inventory (MCMI-III) was performed on them. It should be mentioned, the study has been approved by the Research Ethics Committee of the Faculty of Education and Psychology, University of Tabriz.

Research instruments

- *Structured Clinical Interview of Axis I disorders (SCID-I):* The interview is a flexible instrument that was prepared by First and colleagues (26).Tran and Smith reported 60% for kappa coefficient as inter-rater reliability coefficient for SCID (27). Sharifi and et al performed this interview on a sample of 229 people after translating to Persian. Diagnostic agreement for most specific and general diagnosis was moderate or well (kappa more than 60%). The general agreement (The total kappa index of current diagnoses are 52% and the whole lifetime diagnoses are 55%) is satisfactory (28).

- *Millon Clinical Multiaxial Inventory (MCMI-III):* Million developed Based on the bio-psycho-social theory in 1977 and was revised in 1990. It's a self-report instrument with 175 items that is answered as yes.no and has 24 clinical scales and 4 validity indicators. 14 scales measure personality disorders based on Axis II in DSM-IV and 10 scales clinical syndrome based on Axis I. The cut-off point of the patterns and personality styles is 75-85 and more than 85 score indicates personality disorder. Million and colleagues reported correlation between the MCMI-III and MMPI up to 0.75. In the case of the Persian version, positive and negative predictive potency of the scales are reported 0.92-0.98 and 0.93-0.99 and the diagnosis potency of the whole scales 0.58-0.83. Alpha coefficient of MCMI-III is reported 0.85-0.97 (29).

- *Post-Traumatic Stress Disorder Scale:* Mississippi PTSD Scale has developed by Kean and colleagues. This is a self-report scale and is used to

assess the severity of post-traumatic stress disorder. PTSD scale has 35 items that is classified in 5 groups: Re-experiencing, avoidance, romantic numbing, over-arousal, masochism. Three of these cases relate very closely with DSM criteria for post-traumatic stress disorder. The subjects answer these items with a five-point scale (false, rarely true, sometimes true, very true, and perfectly correct). The range of total scores of an individual will be from 35 to 175. Score 107 and above indicate post-traumatic stress disorder. The reliability of the questionnaire obtained through Cronbach's alpha coefficient from 0.86-0.94 and its validity is based on internal consistency, splitting, re-test within a week, peer test (PTSD inventory) 0.92, 0.92, 0.91 and 0.82 respectively (according to 30).

- *General Health Questionnaire (GHQ-28):* This questionnaire of Goldberg is created for distinction people with mental disorders of cases referred to public medical centers and it is possible to be used for teenagers and adults of any age and in order to discover disabilities in the normal functions and existence of disturbed events in the life. The aim of this questionnaire is distinction between mental illness and health not to attain a specific diagnosis of mental illness. The short form of 28-item was used in this study. Mental health questionnaire includes 4 subscales that are physical symptoms, anxiety symptoms, social dysfunction, and depression symptoms. The score 24 is the cut-off point of this questionnaire. The bisection reliability of the whole questionnaire was reported 0.95 in the Goldberg and Williams ‘study. Reliability of this questionnaire have been reported through test-retest, splitting and Cronbach’s alpha 0.70, 0.93 and 0.90 respectively and Concurrent reliability coefficient with Middlesex questionnaire is calculated 0.55 and construct reliability between 0.72 to 0.87 (according to 1).

- *Ruminative Response Scale (RRS):* The scale consists 22 items that its items are rated on a 4-point scale from 1(almost never) to 4(almost always).This scale’s range is 0.88 to 0.92 through Cronbach's alpha that represents internal consistency of this scale. Intra-class correlation has been reported 0.70 for 5 times measuring. Also the test-retest correlation has been reported 0.67 for more than 12 months. Cronbach's alpha obtained in the Iranian sample by Mansouri is reported 0.90 (according to 31).

- *Beck Depression Inventor-II (BDI-II):* The revision of the Beck Depression Inventory which has been developed to assess depression. The cut-off point of this questionnaire is considered 17. This is a self-reported questionnaire with a 21-point scale that assesses physical, behavioral and cognitive symptoms of depression. Each item has 4 options that is rated on 0 to 3 and determines different degrees of depression from mild to severe. Beck, Steer, & Brown have reported internal consistency of this instrument ranging from 0.73-0.92 with mean 0.86 and alpha coefficient for patient group 0.86 and non-patient 0.81. Also Dobson and Mohammadkhani have obtained alpha coefficient for outpatient 0.92 and for students 0.93 and test-retest coefficient within a week 0.93 (32).

- *Beck Anxiety Inventory (BAI):* This self-report questionnaire is a 21-point scale that is provided to assess the severity of anxiety in adolescents and adults. Four options of each question are rated on a range four part of 0 to 3. Each of test items describes one of common anxiety symptoms (mental, physical symptoms and fear). This questionnaire has a high reliability and validity. Its internal consistency coefficient is 0.92, validity through test-retest method within a week is 0.75 and correlation of items is variable ranging from 0.36to 0.76.For this test 5 types of reliability is measured i.e. content , concurrent, construct, diagnostic and operating reliability that reflects high efficiency of this instrument is to assess anxiety (according to 1). In Iran, Gherabi has reported validity coefficient through test-retest method 0.80 within two weeks and Kaviani and Mousavi have reported reliability coefficient about 0.72 and test-test-retest validity coefficient 0.83 within a month and Cronbach's alpha 0.92 (refers to 32).

- *Rosenberg Self-Esteem Scale (RSE):* The RSE consists of 10 items and each question has been rated on 4-point scale: strongly agree, strongly disagree, agree and disagree. It has high reliability and validity as in Hemmati’s research Persian translation questionnaire of Cronbach’s alpha was estimated 0.78. Mohammadi studied reliability and stability of a sample of 185 students at Shiraz University.

Cronbach’s alphas of scale in splitting and test-retest method with intervals were obtained 0.69, 0.78 and 0.68 respectively (according to 1).

In the present study, the subjects were entered to 12 sessions of treatment plan after testing with Mississippi post-traumatic stress and general health questionnaires and structured clinical interview.

In this study, manual of editing treatment sessions was set according to Greenberg’s theory, using existing resources, McCarthy and Barber (12), Greenberg and Watson (17), Greenberg and Paivio (19), Paivio (23), Paivio and Pascal (24),Watson and

Goldman (33), Leahy et al. (34), Paivio and Nieuwenhuis (35), Elliott et al. (36), Greenberg (8 and 37), Leahy (38) and knowledge and clinical experience of researchers in this field.

Table 1. The content of therapy sessions

1st session	Knowledge and setting therapy communication , knowledge of the treatment rules, assessment of the problem's nature and relationship, assessment of objectives and expectations of treatment and execution of pre-test
2nd session	Diagnosis of negative interactive cycle of romantic relationship, clients understanding the basics of emotion-focused therapy and the role of emotions in interpersonal interaction , reconstruction of interaction and increasing flexibility of clients
3rd session	Expression and understanding the impact of irrational thought on emotional disturbance, introducing four styles with error and extracting information from the romantic relationship
4th session	Continuity and knowledge, communicating with the clients and the formation of a bilateral link, identifying the processes of underlying romantic cognitive, identifying the condition of creating problem
5th session	Accessing not to identify feelings that are basis of interactive opportunities, Focusing more on emotions, needs and fears of romantic relationship and validation the experiences, needs and desires of clients, focusing on secondary emotions that are revealed in an interactive cycle and discovering in order to achieve the underlying and unknown emotions, discussing and processing primary emotions and raising awareness of clients from the primary emotions and hot cognition, studying of attachment needs
6th session	Re-framing the problem in terms of the underlying feelings and attachment needs, focusing on the client's ability to express emotions, informing the clients about the impact of fear and self-defense mechanisms of cognitive and emotional processes, Overcoming avoidance or defense processes such as over control of romantic experience and feelings of guilt and shame about the abuse and review over control affection
7th session	Focusing on the internal experience of references, assessment of emotion. Acceptance of destructive emotional experience, identify hot points, abreaction in writing. (From the first session until the end of this session, more focus is on rapport and reducing negative emotions such as non-adaptive fear and shame).
8th session	Relaxation, Identifying emotional schemas, Emphasis on acceptance of experience, imaginative confrontation and performing empty chair (resolving issues with abusive or harmful people)
9th session	Highlighting and re-description of event and relationship, referring to be normal. Analysis of dreams (this approach has been adopted to reduce the nightmare with focused principles on emotions. Evoking images of nightmares while clients are awake, the use of the first- person and present tense in describing the nightmare and re-telling dream and ending more satisfying dream is important).
10th session	Strengthening emotional processing, tracking unresolved feelings. Restructure emotions, evoking and provoking bad feelings again, providing support for emotions. And resolve emotions again about the abusive person
11th session	Facilitating the expression of needs and desires and creating emotional involvement, development of primary emotional experience and understanding of the needs and internal interests. Removing memories and relaxation techniques to imagine another story. Again, using imaginative confrontation techniques derived from Gestalt to review trauma and help to express suppressed emotions and techniques such as talking to an empty chair, and express thoughts and current feelings about abuser
12th session	Strengthening the changes that have taken place during treatment, to assess the changes. And finally, to answer the questions and review

Each client received 12 therapy sessions. PTSD scale and Rosenberg Self-Esteem Scale (RSE), Beck Depression Inventor-II (BDI-II), Beck Anxiety Inventory (BAI), Ruminative Response Scale (RRS) were completed by clients in baseline, final and follow-up sessions. Sessions were held once a week. To control possible interfering variables and according to the multiple baseline design, the first and second clients were entered to treatment plan in the second session and as the same way the first and third clients were entered to treatment plan in the fourth session. At the end of treatment phase (twelfth session), the questionnaires were completed again by clients. Follow-up period was three months. In this study, graphing methods and the clinical significance were used for data analysis. In addition, formula was used for the percentage of the clients' improvement.

This formula was used by Blanchard and Schwars for the first time. In the improvement percentage formula, the score of pretest is subtracted from the score of posttest and divided to the pretest score. If improvement percentage is at least 50, the result can be considered significant clinically (25).

Results

The demographic characteristics of women clients are mentioned in Table 2.

Table 2. Demographic characteristics of clients

Client	Age (Year)	Relationship period	Ending period	Level of Education	The severity of abuse	Previous treatment
A	22	17 months	5 months	Undergraduate	Loss of virginity	No
B	19	13 months	8 months	Undergraduate	Loss of virginity	No
C	23	19 months	3 months	Masters student	virginity	Yes, 3 sessions with a psychiatrist and a course pharmacotherapy

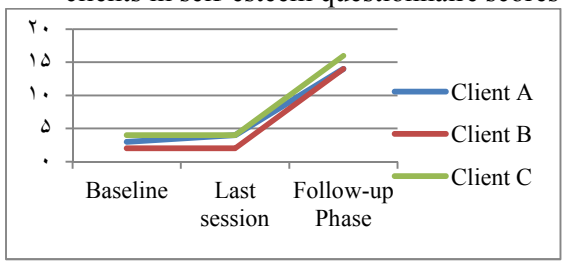
PTSD and self-esteem questionnaire scores are presented in Table 3.

Table 3. Comparison clients' scores on PTSD and Self-esteem questionnaire in baseline, last session and follow up phase

Test	Baseline			Last session			follow up phase			Improvement level			Total improvement percentage
Clients	A	B	C	A	B	C	A	B	C	A	B	C	All three clients
PTSD	135	149	148	65	56	56	56	57	64	56%	61%	56%	58%
Self-esteem	3	2	4	4	4	4	14	14	16	85%	85%	75%	82%

According to Table 3, all three clients, in general, have improved in PTSD and self-esteem scores as clients A, B and C have improved in PTST scale 56, 61 and 56% and in self-esteem scale 85, 85 and 75% respectively. Table 4 indicates clients' scores in depression, rumination and anxiety in baseline, last session and follow-up phase.

Graph 1. The improvement percentage procedure of clients in self-esteem questionnaire scores



Graph 2. The improvement percentage procedure of clients in PTSD questionnaire scores

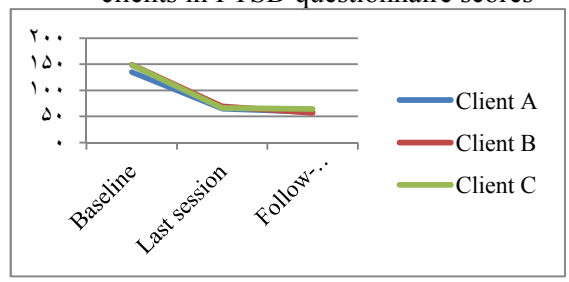
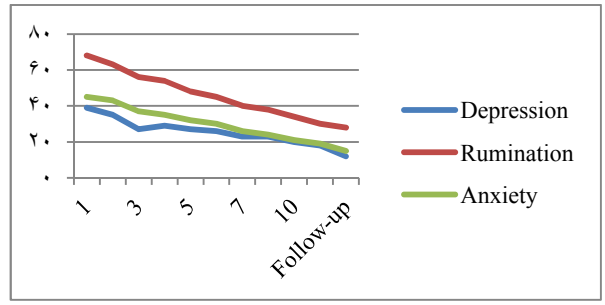


Table 4. Comparison of clients' scores on depression, rumination and anxiety in baseline, last session and follow-up phase

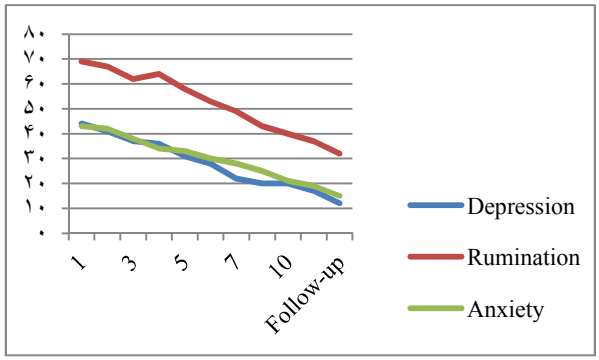
	Test	Session1	Session2	Session3	Session4	Session5	Session6	Session7	Session8	Session10	Session12	Follow-Up	Improvement Rate
Client A	Depression	39	35	27	29	27	26	23	23	20	18	12	69%
	Rumination	68	63	56	54	48	45	40	38	34	30	28	58%
	Anxiety	45	43	37	35	32	30	26	24	20	19	15	67%
Client B	Depression	44	41	37	36	31	28	22	20	20	17	12	72%
	Rumination	69	67	62	64	58	53	49	43	40	37	32	53%
	Anxiety	43	42	38	34	33	30	28	25	21	18	16	62%
Client C	Depression	41	40	35	32	30	24	23	21	17	15	13	72%
	Rumination	73	71	67	61	55	47	47	42	36	32	29	53%
	Anxiety	47	46	43	38	33	31	28	25	23	19	16	66%
Total Improvement Percentage	Depression												71%
	Rumination												65%
	Anxiety												55%

As Table 4 demonstrates, clients A, B and C have improved in the depression, 69, 72 and 72%, the index of rumination, 58, 53 and 53 percent, and the anxiety index of 67, 62 and 66% respectively.

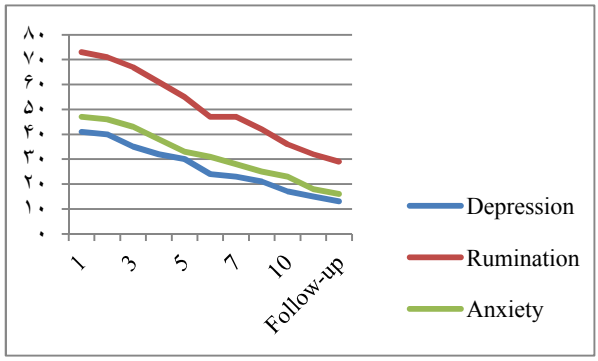
Graph 3. The improvement percentage procedure of client A in depression, rumination and anxiety questionnaires



Graph 4. The improvement percentage procedure of client B in depression, rumination and anxiety questionnaires



Graph 5. The improvement percentage procedure of client C in depression, rumination and anxiety questionnaires



Discussion

Results of preliminary study of focused therapy effectiveness on emotions confirm as short-term and comprehensive treatment for sexual abuse in romantic relationships. EFT therapy brought statistically and clinically significant improvement in various fields for clients. In addition, there were achievements of 3 months after the end of treatment. The most important finding of this study was significant changes in the syndromes of post-traumatic stress disorder. Also other research variables like reduction symptoms of depression, anxiety, rumination, and increasing self-esteem has been effective. To date, emotion-focused therapy, is the only individual therapy that researches have been done systematically in various countries and with a variety of emotional, physical and sexual abuse (17,24).There wasn't or we didn't access research which directly has been done about emotion-focused therapy of sexual victims, in Iran. However the findings of this study are consistent with the study by Greenberg Discussion. However the findings of this study are consistent with the study by Greenberg Paivio (20), Greenberg and Watson (17), Paivio and Shimp (23), Johnson and Keeler (39), and Paivio and colleagues (24).

For discussion about the success of emotion-focused therapy, we use the six criteria of efficiency (40). Ingram, Hayes and Scott believe that we should study the results of intervention based on the six variables (according to 25).

1. Magnitute of change (how much reduction occurred in the primary target of therapy?)

In this study, treatment the symptoms of PTSD, anxiety, depression, self-esteem, and rumination were targeted therapy. Results of table 3 and graph 1 show that therapy was successful in reducing PTSD symptoms. In total, approximately 60% showed improvement and this trend has continued until the end of follow-up. In response to the question of how current treatment explains changes, it could be that, it could be that, in emotion-focused therapy, clients are suffering distress moreover they are faced with severe unspeakable emotions, failure to satisfy needs and expectations and devastating memories of abusers. They aren't able to heal the trauma and increase their capacity to express emotions, processing and resolution past experiences, and this is their first treatment task (1,4,24).

Emotions give chance to express their feelings to anything, this expression is connector between the inner and outer experience ,this has two way interaction with knowledge and helps people evaluation situations in which the values, needs, goals or personal interests are concerned .According to treatment based on emotions, states of negative affect and widespread damage attachment, lack of attention to the needs and demands of internal negative interaction patterns and inappropriate emotional experience, create problems for the individual. Therefore, during treatment, defective interactive cycle, attachment injuries and problematic emotions should be identified to improve the freedom of the problems and appropriate remedial action should be done to correct these issues. Change on EFT occurs when emotional responses, base of interactive opportunities, are experienced and re-processing. Reprocessing emotional interactive patterns enables the individual to provide new experiences of himself and the other and act in a completely different way (4).

The treatment is supposed that the therapeutic relationship and emotional processing of trauma memories are the primary mechanism for change. A sympathetic and cooperative relationship provides a good platform to search for trauma components and a corrective interpersonal experience, especially in people with problems caused by the lack of empathy

and interpersonal control. Such interventions evoke trauma-related maladaptive emotions (like fear and shame) and clients learn to tolerate these experiences and create new meaning to them. In this treatment, the prohibition adaptive emotions (such as anger and sadness) are evoked until, the adaptive functions of this excitement would be available and this is primary source for new information that changes the meaning of the previous experience (4, 35).Intensity of destruction after sexual trauma, specifies distinctive features of therapy for the issues of sexual abuse in romantic relationships. Most importantly, in early treatment, the visual exposure is a stimulus for the evoking of trauma (trauma matters) (15,41).

Narrative of the traumatic experience, in turn, creates a distance from these experiences, and clients learn to tolerate and adjust intense emotions by soothing interactions with the therapies (20,35). Chronic suppression of emotions will lead to the accumulation of stress and tension that both of them have role in physical health problems (42), and non-adaptive anxiety or anger (43). Post-traumatic stress symptoms, for example, avoiding memories and emotions associated with the trauma, lead to preserve the disorder by avoiding processing of emotional trauma (6,21,23). Avoiding emotions will have detrimental effect on performance. This is evident in disorders such as alexithymia.

Other target of therapy in this study was self-esteem, anxiety, depression and rumination. Results of Table 2 and Table 3 and Figure 2, 3, 4, and 5 showed that patients were successful in reducing symptoms of depression, anxiety and rumination. In total, respectively, 80%, 70%, 65% and 55% improvement in symptoms of depression, anxiety, and rumination were showed, and this trend has continued until the end of follow-up. To illustrate how improvements made in emotion-focused therapy we can say that;

Therapy based on emotion by creating positive attachment for people will cause to restore autonomy (39). In fact, the ability to deal with emotions facilitates the persons that identify emotions in themselves and others, and understand interaction of it on behavior to express the appropriate action to emotions. Increase of positive emotional regulation strategies leads to deal and solve adaptive problem with stressful opportunities, and continuous of this trend leads to improve reduced self-esteem of victim. Low self- esteem victim believes that the current situation is unsolvable, avoids dealing with emotions and images of the traumatic event through repetitive thoughts of anxiety and rumination -as a mechanism to cope with the internal insecurity (44)-. Rumination after repetition and the passage of time leads that person 'mood becomes negative and this trend, causes person to experience more symptoms of depression and anxiety. The sequence of these events- strategies of maladaptive emotional regulation- leads to increase in negative emotion in result of double cycle of emotion dysregulation and negative affection (45), person engaging in this cycle has just exhaustion and demoralization achievement. In this regard, Teasdale (according to 46) refers to the same processing as block of cognition. In turn, block of cognition helps negative mood be harder and more stable and increase of negative affection reduces more the cognitive resources and eliminates the use ability of re-evaluation. So in EFT therapy sessions, after that person understands the processes and regulates his emotions without avoidance in the safe therapy environment, he will eventually use less repetitive thoughts such as rumination to avoid them. And in sequence of this path, symptoms of depression and anxiety decreases and consequently, the patient's self-esteem in an interaction leads to improve mood and normal affect and this would restore the lost self-esteem of victim. Totally, it is possible to ensure the effectiveness of the treatment (47) when changes are observed (meaningful) after the sequential implementation of therapy variables for each test in at least three subjects.

2. Universality of change (what percentages of the people have changed and what percentage have not changed?)

The results show that clients achieved 58 percent of overall improvement in the severity of PTSD symptoms, at the end of treatment. In other word, EFT therapy has reduced about 60 percent of PTSD symptoms intensity of clients. Clients have achieved respectively 71%, 55% and 65% overall improvement in the clinical syndrome of depression, anxiety and rumination, at the end of therapy.

Clients are asked to imagine an abuser in an empty chair, face their inner experiences, and express their thoughts and emotions directly to the supposed person. This accesses speed of fundamental emotional processes (including fear, avoidance, and shame about themselves) and makes them explorable (35).The frequency and duration of this imaginative exposure are variable, according to unique processes of each client and his therapy needs. Issues are explored in the client's interaction with therapist when clients don't want or are not able to participate in this exposure. The performance of therapist during exposure is:

Encouraging the psychological contact with

imagined person, evoking the associated with abuse memories, encouraging the sense of justification of unsatisfied needs, changing the perception of self and others. Focus on experience and display of two chairs can be used to reduction of avoidance and self-criticism with imaginative exposure. Clients are encouraged to focus deeply on their experience of abuse. This procedure is different from imaginative exposure where clients are encouraged to remember the abuser clearly and express thoughts and emotions to the therapist rather than participating in a conversation with the imagined person in the empty chair. Barriers of emotions experience are explored in interaction with the therapist (17, 35). For, the main focus on resolving issues related to the abuser is the principles of intervention and the therapist performance, in EFT therapy. Empathic response of the therapist to explore clients' emotions and sense of self, others and traumatic event, is highly effective in reducing clinical symptoms.

3. Generality of change (how much change has occurred in other areas of life?)

Consequences of sexual victimization in romantic relationship are reduction of self-esteem and social relationships and drop of school performance. All three clients were students, so amount of dealing with overdue tasks and curricula, recreation and interpersonal functions may be a good indicator of changes in educational and social fields. Results of last session and follow-up level showed positive changes were. To measure changes in performances between individual, clients were requested to ask their roommates the amount of their change on a continuum of 0 to 10 (0 the lowest and 10 the highest change) that a, b, and c clients achieved 9, 7, 7, grades respectively; and as self-esteem questionnaire shows, scores of three clients have growing trend at the end of the sessions and follow-up.

4. Acceptability (To what extent people involved in the treatment process and have completed it?)

The problem arises in some of the research reports is that drop of clients are not reported as one of therapy results. According to Kazdin (25) drop of subjects must be calculated as one of the therapy variables. Because none of the clients did not drop and completed entirely the treatment process, and they had good cooperation in the follow-up period, it is showing their high participation. According to Greenberg and Paivio (20) and Greenberg and Watson (17), this treatment is safe and attractive for them, as the client learn to tolerate and regulate intense affection by soothing interactions with the therapist in EFT treatment.

5. Safety (whether as a result of the treatment, mental and physical health of patients have decreased?)

The results of this study show that, patients' Status has improved in the majority of therapy targets, although the improvement in patients has been with fluctuations and differences, and has not had negative effects and consequences. According to clients report, treatment doesn't cause any trouble for them. Although none of the clients' had a specific complaint of the treatment process, cannot simply claim that the treatment has not imposed any negative consequences to them, because any tool was not used to evaluate the negative consequences of treatment.

6. Stability of treatment gains (How much are the treatment gains sustained?)

Follow-quarter results suggest that not only achievements have been preserved in most therapeutic targets, but also some patients had even more progress than the last session in some of the targets. Importance of study results will be doubled when person sexes in romantic relationship desirably and shows post-traumatic stress disorder because of cultural pressures after rejection by sexual partners and feels being victim and abused .This is because of that person knows the social system and more importantly family will not accept her and reject her. In such cases, there is the likelihood of high-risk behaviors such as suicide, run away from home and so on. So, the psychological and psychiatric interventions will be important in such cases and the results of this study and similar studies can be helpful, but it should be consider that arrival of family is very important in the therapy process because as the brief mentioned acceptance of family is very important and ensures effectiveness of psychological intervention and its continuity. Therefore, a limitation of this study was absence of family arrival in treatment, according to the Iranian cultural context and importance of intercultural studies it is recommended that a preliminary study is followed on the etiology and intervention.

Conclusion

Therefore, in this study, girls who had sex their lovers with their consent and then were rejected by him, suffered from post-traumatic stress disorder, improved in the process of emotion focused therapy. It seems that this improvement is the result of breaking the avoidance cycle of negative emotional experience of the unacceptable recurring devastating event obtained during reconstruction of damaged attachment of the patient in the sessions. In all sessions, victims had reduced negative mood and

affect in an interaction with restored self-esteem and overcoming post-traumatic stress disorder through learning in accepting emotions, understanding and processing emotions and eliminating emotion dysregulation.

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