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Comparison of the Effectiveness of Emotion-Focused Therapy and Cognitive Behavioral Therapy on Sexual Self-Efficacy in Women with Breast Cancer

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Abstract

Background: Breast cancer is a disease, and the suffering women are at risk of experiencing disease-related turmoil and pressures.

Objective: This study aimed to compare the effectiveness of emotion-focused therapy and cognitive-behavioral therapy in sexual self-efficacy among women with breast cancer.

Methods: This semi-experimental study was conducted based on a pretest-posttest using follow-up and a control group. The statistical population of this study was all married women with breast cancer referred to Milad Hospital, Tehran, Iran, in 2020. In total, 45 patients who met the criteria for entering the study were selected as the final sample size using the non-random and available sampling method and were placed in two experimental groups and one control group (15 cases per group). At this stage, all three groups responded to the sexual self-efficacy questionnaire as a pretest, and the two experimental groups received cognitive-behavioral and emotion-focused therapy. On the other hand, the control group was requested to wait. After completing the course, all three groups responded to the questionnaire listed as a posttest. After four months, the follow-up test was administered again. The obtained data were analyzed in SPSS software (version 22) through covariance analysis test and paired comparison of measurement stages.

Results: The results showed that both emotion-focused therapy and cognitive-behavioral therapy were effective in sexual self-efficacy (P<0.001); however, there was no difference between the two treatments in terms of sexual self-efficacy.

Conclusion: The results of this study showed the effect of emotion-focused approach therapy and cognitive-behavioral therapy as supportive methods in increasing sexual self-efficacy in women with breast cancer.

Keywords: Breast Neoplasms, Cognitive-Behavioral Therapy, Emotion-Focused Therapy, Female, Self-efficacy

Introduction

Breast cancer is a disease, and the afflicted women are at risk of experiencing disease-related turmoil and pressures. Moreover, many of them experience adaptation problems directly related to a cancer person's life, such as the turmoil associated with the commencement of the disease and the consequences of cancer (1). In this context, sexual self-efficacy in women with breast cancer is one of the most important issues that plays an important role in feeling healthy and improving the quality of life (2-4). According to studies, the suffering women in different countries state that their sexual function has changed under the influence of the disease and its treatment (5). Manganiello et al. (6) also found in their study that cancer impaired sexual self-efficacy and self-esteem; moreover, it caused negative body image, as well as decreased sense of femininity and sexual activity.

The concept of sexual self-efficacy derived from Bandura's self-efficacy was introduced by Vaziri and Lotfi Kashani (7). Sexual self-functioning is a belief that every person has about his/her ability to function effectively in sexual activities and to be desirable for his/her sexual partner (7). Such a belief is a kind of self-assessment of ability and efficiency in sexual behavior; however, self-efficacy as a central concept referring to the perception of abilities to perform an action and follow desires; in addition, it depends on each person's sense of control over their environment and behavior, which affects the level of endurance, commitment, and effort to achieve the goal (8). Considering that breast cancer has a direct relationship with decreased function and weakness in female sexual self-efficacy (9), addressing this problem and educating these patients to improve their marital relationships leads to the strength of their sex life, and the young age of many of its patients does not cause them to stop their sex life.

One of the short-term therapeutic strategies to help women involved in breast cancer in working

with emotional disturbances is emotion-focused therapy (10). In the emotion-oriented approach, the approaches of Gestalt and the systemic approach are combined with constructive thinking, as well as passion and commitment along with a look at romantic relationships that are best expressed in attachment theory (11). This approach is a structuralist one and focuses on the development and experiences of couples, especially those of emotional origin, while at the same time, it is a systemic approach since it focuses on people's interactive patterns (12). According to the findings of Timulak et al. (13), emotion-focused therapy is effective in forgiveness and reconciliation of couples and creating emotional solidarity between them. On the other hand, cognitive-behavioral therapy is a new development in psychological therapy that has been able to attract a lot of interest in clinical specialists. The main reason for this interest is that cognitive-behavioral methods, unlike other methods of behavior therapy, deal directly with emotions and thoughts. In this type of treatment, the patient is helped to change his distorted patterns and dysfunctional behavior with the help of regular discussions and organized behavioral practices (14-15).

The necessity of this study is that the quality of marital relationships is related to many long-term physical and psychological consequences; moreover, it has many negative consequences on society and family. Accordingly, it is necessary to pay attention and improve the quality of marital relationships and prevent these traumatic consequences that have become one of the priorities of psychologists and health professionals. The strength of marital relationships without satisfactory sexual relationships is compromised in a healthy marriage. The existence of desirable sex in a way that can provide consensual support has a very important role in the success and sustainability of the family center. For these reasons, identification of self-efficacy levels in women with breast cancer, as well as their sexual adjustment status, are very important in teaching them positive health behaviors, improving their self-care behaviors, and helping them adapt to the disease. The results can be provided to therapeutic clinics and hospitals so that the problems of women with breast cancer can be improved by using the findings. As a result, research in this field is considered important and necessary.

Objective

This study aimed to compare the effectiveness of emotion-focused therapy and cognitive-behavioral therapy in sexual quality of life and sexual function among women with breast cancer.

Methods

This semi-experimental study was conducted based on pretest-posttest using a control group. The statistical population of this study was all married women with breast cancer referred to Milad Hospital, Tehran, Iran, in 2020. In total, 45 patients who met the inclusion criteria were selected as the final sample size using the convenience sampling method and were placed in two experimental groups and one control group (15 cases per group). The sample size was estimated at 30 people (15 cases per group) by G*Power software (version 3.1) (no need for formula, and by specifying the type of statistical tests, the test power, effect size, and error level were 0.80, 0.40, and α= 0.05, respectively). After selecting the subjects, treatment courses, objectives, and ethical considerations were explained to the participants, and after the end of the course, they responded to the sexual self-efficacy questionnaire. During this period, the control group waited and no treatment was applied to them. After four months of retesting, a follow-up test was administered. Inclusion criteria were minimum education level of diploma, age range between 20 and 50 years, and breast cancer in the second stage. On the other hand, the participants with any physical and mental illness other than cancer leading to interference with research variables, and those who were absent in more than two sessions of treatment were excluded from the study.

Regarding the ethical considerations, participation in this study was completely optional. Before starting the project, the participants became familiar with the specifications of the plan and its regulations. People's attitudes and beliefs were respected, and the members of the experimental and control groups were allowed to leave the research project at any stage. In addition, the members of the control group could, if they were interested, receive the intervention performed for the experimental groups in similar treatment sessions. Furthermore, all documents, questionnaires, and confidential records were only available to the executors, and informed written consent was obtained from all volunteers. This study was derived from a Ph.D. thesis of Psychology submitted by the International University of the Emirates (IR.SBMU.RETECH.REC.1399.769) and approved by the Deputy of Research and Technology of Shahid Beheshti University of Medical Sciences, Tehran, Iran (23/12/2020).

Sexual Self-Efficacy Questionnaire:

This scale was based on Schwarzer's general self-efficacy questionnaire and was created by Vaziri and Lotfi Kashani. This 10-item questionnaire is rated on a four-point Likert scale from 0 (not correct at all) to 3 (completely correct). The lowest score is zero and the highest score is 30, and in the interpretation, it is divided into three categories of low, medium, and high sexual self-efficacy. Moreover, this scale includes 20 questions that measure sexual satisfaction of

married subjects rated on a four-point Likert scale from never (0) to always (3).

In a study conducted by Vaziri et al. (7) to evaluate the concurrent validity of this questionnaire, the correlation coefficient of the sexual self-efficacy questionnaire with the total scores of sexual function index was obtained at 0.80; moreover, the sexual satisfaction was determined at 0.81, which shows a high correlation between the scores of these scales. In preliminary studies, the reliability of the sexual self-efficacy questionnaire was 86.0 using Cronbach's alpha and 0.81 by the Spearman-Brown method (7). In this study, the reliability of this questionnaire was obtained at 0.84 using Cronbach's alpha method.

Table 1. Cognitive-Behavioral Therapy Protocol (12)

Session	Content
First	Initial familiarity and establishing therapeutic relationships, presenting main complaints of women, introducing a brief introduction of the type of treatment, collaborating with the research sample in determining the goals of the treatment protocol, determining the relationship between cognition, emotion, and behavior, choosing goals and diagnosis of targets and agreeing on home assignments, recording life events based on ABC model
Second	General problems of women in the form of the cognitive-behavioral model, triangular cognitive integration in therapeutic strategies, use of standard behavioral activation techniques, re-projection of negative thoughts, and presentation of inefficient thoughts registration sheet.
Third	Continuing working with self-help thoughts, reviewing inefficient thoughts of patients, and challenging self-help by the Socratic method.
Fourth	Identifying the underlying beliefs and how they are activated in specific situations, using the downward arrow technique, and investigating some of the related problems of patients.
Fifth	Developing awareness of underlying beliefs, strengthening positive self-talk, using behavioral techniques to replace positive thoughts instead of negative thoughts.
Sixth	Using cognitive-behavioral techniques on assertiveness, problem-solving, and teaching social skills to women
Seventh	Further identification of unconditional beliefs and nuclear beliefs, weakening unconditional beliefs by questioning them by Socratic method, and grading negative beliefs on a scale of 0 to 100 degrees
Eighth	Continuing to produce and develop alternative positive beliefs through the development of social and communication skills, development of problem-solving skills and courageous behaviors, grading alternative thoughts, creating readiness to use the methods learned in future life situations.
Ninth	Communication skills training, group discussion, and presenting complementary activities. In this session, people were taught efficient verbal response style and active listening skills, and they were asked to pay attention to the reaction of others to these verbal response styles, and at the end of the session, the dependency contract was made with patients (a behavioral treatment method whereby to exchange rewards for expressing behaviors). (Agreements are made between the members of the group)
Tenth	Training self-control and alertness skills, group discussion, presenting complementary activities, and post-test implementation. It should be noted that in each session, the contents and home assignments of the previous session were reviewed, and at the end of the session, new assignments were assigned to the subjects.

Table 2. Emotionally-Focused Couple Therapy Protocol (11)

Session	Content
First	Reviewing people's opinions about the concepts, assessing the way they deal with problems, discover barriers to attachment and emotional conflict within and between individual and interpersonal, assessment of sexual functions status
Second	After the session, the subjects were asked to attend separately for few minutes. Topics included discovering information that is not possible in the presence of a spouse, such as extramarital relationships, the trauma of previous personal attachment that influences current relationships, assessing their fear of revealing secrets.
Third	Discovering the insecure attachment and fears of each individual, helping to be more open and self-exposed, continuing the continuity of treatment
Fourth	Clarifying key emotional responses, expanding the emotional experience of each individual in relation and the emergence of new elements in the experience, coordinating the therapist's diagnosis with clients, accepting the negative cycle, reviewing and revising relationships
Fifth	Increasing the identification of attachment needs, deepening personal relationship with emotional experience, improving the interactive situation
Sixth	Determining the appropriateness of the therapist's framework with people's experience, deepening with conflict, accepting more people from their experience, promoting new methods of interaction focus on oneself and not the other
Seventh	Rebuilding interactions and changing events, more people's conflict with each other, clarifying desires and dreams
Eighth	Restructuring interactions, changing the behavior of a harmonious spouse, creating harmonization in the inner sense of self and relationship, changing interactions overcoming barriers to the positive reaction
Ninth	Intimate conflict, staying on the line of treatment and not getting out of it, coordinating new situations that marital relationships have created, identifying and supporting constructive interactive patterns, creating a secure attachment, building a happy story of the relationship
Tenth	Maintaining future interactions change, determining the difference between past negative interaction patterns in the initial and present sessions, maintaining emotional involvement to continue strengthening the bond between them, performing posttests

At the descriptive level, many distribution tables, percentages related to demographic characteristics, and descriptive statistics were used to investigate the research variables in the sample by groups. At the inferential level, according to the level of data measurement and statistical assumptions (normality, homogeneity of variances, homogeneity of covariance variance matrix, and

croissant assumption), mixed variance analysis and multivariate variance analysis method and covariance were utilized. Furthermore, Scheffe and Bonferroni's follow-up tests were used and analyzed in SPSS software (version 22).

Results

The mean±SD ages of the participants in the emotion-focused, cognitive-behavioral, and control groups were obtained at 38.56±7.49, 36.33±6.21, and 37.10±6.54, respectively.

Table 3. Mean±SD of Sexual Self-efficacy Variable at the Pretest, Posttest, and Follow-up in Three Groups

Variable		Pretest		Posttest		Follow-up	
		M	SD	M	SD	M	SD
Sexual self-efficacy	Emotion-focused	14.20	3.15	20.00	5.39	21.13	5.82
	Cognitivebehavioral	13.13	3.22	19.67	5.74	20.80	5.96
	Control	13.89	3.29	14.15	3.56	14.21	3.60

Kolmogorov-Smirnov test was used to investigate this assumption. Since Kolmogorov-Smirnov test values were not significant for the sexual self-efficacy variable in the experimental and control groups (P<0.05), it can be concluded that the distribution of scores in these variables is normal. To study the default parity of variances, Leven's test was utilized. The values of statistic F, which indicates the amount of loon test to assess the homogeneity of the variances of the experimental and control groups were not significant (P<0.05). According to this conclusion, the default results of variance parity of experimental and control groups are confirmed in the research variables. Before performing the analysis of variance by repeatedly measuring the default result of Mauchly's sphericity test, the scores of variables are presented for covariance matrix homogeneity. The results of Mauchly's sphericity test showed the default homogeneity of the covariance matrix.

Table 4. Variance Test Results with Repeated Measurements Related to Within-Subject and Between-Subject effects

Effects	Source	SS	Df	MS	F	P
Within-subject	Time	661.52	1.69	390.46	86.20	0.001
	Time*Group	269.49	3.38	79.53	17.55	0.001
Between-subject	Group	547.97	2	273.98	14.81	0.001

In Table 4, the results of the analysis of variance are shown by repeated measurements to investigate the intra-test and inter-test effects. As can be seen, the variables of sexual quality of life and sexual self-efficacy were significant due to time (P<0.01); therefore, there is a difference among pretest, posttest, and follow-up in terms of these variables in the experimental and control groups. There is an interaction between the group and time in the sexual self-efficacy variable (P<0.01). In Table 5, emotion-focused, cognitive-behavioral, and control groups are compared using Bonferroni's test for each variable and each stage.

Table 5. A Paired Comparison of Experimental and Control Groups in Measurement Stages in Research Variables

Variables	Stages	I	J	Mean Diff. (I-J)	Std. Error	P
Sexual self-efficacy	Pretest	Emotion-focused	CBT	1.06	0.959	0.272
			Control	0.600	0.959	0.535
		Cognitive-behavioral	Control	-0.467	0.959	0.629
	Posttest	Emotion-focused	Cognitive-behavioral	0.333	0.962	0.731
			Control	6.00	0.962	0.001
		Cognitive-behavioral	Control	5.66	0.962	0.001
	Follow-up	Emotion-focused	Cognitive-behavioral	0.333	1.28	0.796
			Control	7.00	1.28	0.001
		Cognitive-behavioral	Control	6.66	1.28	0.001

Regarding the variable of sexual self-efficacy, the results of the table indicate that at pretest, there is no difference among the emotion-focused, cognitive-behavioral, and the control groups (P>0.05); however, at the posttest and follow-up, a significant difference was observed between both treatment groups and the control group (P<0.01). According to the means of the groups, the scores of people treated with emotion-focused and cognitive-behavioral therapy have increased indicating the effect of both treatments on the sexual self-efficacy of the subjects. The comparison of the two treatment groups in Table 5 also shows no difference between the two groups (P>0.05).

Table 6. Pair Comparison of Measurement Stages by Groups

Variables	Stages	I	J	Mean Diff. (I-J)	Std. Error	P
Sexual self-efficacy	Emotion-focused	Pretest	Posttest	-5.80	0.883	0.001
			Follow-up	-6.93	0.620	0.001
		Posttest	Follow-up	-1.13	0.608	0.069
	Cognitive behavioral	Pretest	Posttest	-6.53	0.883	0.001
			Follow-up	-7.66	0.620	0.001
		Posttest	Follow-up	-1.13	0.608	0.069
	Control	Pretest	Posttest	-0.400	0.883	0.653
			Follow-up	-0.533	0.620	0.394
		Posttest	Follow-up	-0.133	0.608	0.828

In Table 6, considering the sexual self-efficacy variable, the results show a significant difference of pretest and pretest with follow-up (P<0.01). However, there was no significant difference between posttest and follow-up (P>0.05), and this finding shows that emotion-focused and cognitive-behavioral therapies are effective in increasing sexual self-efficacy among women with breast cancer, and their effect has remained persistent at the follow-up.

Discussion

The results of this study show that emotion-focused therapy and cognitive-behavioral therapy have a significant and almost equal effect on sexual self-efficacy. Kane et.al (14) examined the effect of the cognitive-behavioral approach in the treatment of inhibited disorder and showed that couples' cognitive-behavioral style was effective in increasing female sexual arousal (14). The findings of a study conducted by Ahmadnia et al. (16) showed a decrease in the anxiety and sexual avoidance of subjects as a result of behavioral and cognitive therapies. Consistent with the findings of the present study, Ter Kuile et al. (17) demonstrated that cognitive-behavioral therapy effectively increased the frequency of sexual intercourse. In justifying the lack of alignment, it can be said that due to the sinful view of sexual issues in Iran, appropriate protocols were not developed for the effectiveness of sexual function in identifying and determining the causes of sexual disorders, as well as their treatment in Iranian society. Moreover, the result of a study performed by Hissa et al. (18) showed that emotion-focused therapy was effective in breast cancer patients' experiences of comorbid anxiety and depression that was in line with the finding of this study.

Regarding the effect of the emotion-focused approach on the quality of sexual life in women with cancer, it can be stated that the main indicator used in most existing studies to investigate the concept of quality of sexual life is the occurrence of sexual dysfunction (18). Sexual dysfunction can affect sexual self-efficacy (19). In explaining the effectiveness of emotion-focused therapy in sexual self-efficacy, it can be stated that the effect of emotion-focused therapy on sexual self-efficacy is such that people's belief in their abilities, even when a person has a defect in their body, can keep their functions steady. With this belief, a person can influence the consequences of their life and feel more in control of it. Accordingly, sexual self-efficacy can also be considered a belief that each person has sexual activities about their ability to function effectively and to be desirable for their sexual partner. Such a belief is a self-assessment of ability and efficiency in sexual behavior (20).

For this reason, the level of self-esteem, positive attitude, and empathy of spouses are related to better and more complete sexual gratification and feelings of happiness; moreover, sexual relationships and expression of affection increase marital adjustment (19).

In fact, in breast cancer patients, when people lose a part of their body that is valuable to them, they lose the source of social support and are plunged into isolation; therefore, these physical and role changes cause changes in the mental and physical image, resulting in a decrease in self-esteem (21). As a result, this decrease in self-confidence is effective in their

social interactions that reduces self-efficacy. Emotion-focused therapy is an inflexible reception of one's attention to his emotions, and by creating emotional self-regulation that leads to a non-judgmental perception of the individual's cognitive process, it increases his adaptive and efficient behaviors and encourages him to accept what he is now, changes his cognition, increases acceptance in him, and elevates the person's self-confidence and self-efficacy. Furthermore, sexual self-functioning in breast cancer patients can focus on sexual feelings, experiences, and processes in a function without judgment in just the present moment, and increase their acceptance of themselves, disease, and body image.

One of the components of cognitive-behavioral therapy in the present study was challenging and changing women's dysfunctional sexual beliefs. These beliefs have characteristics, such as deep, inclusive, frequent themes derived from memories, emotions, cognitions, and physical emotions, and when activated, it involves a high level of emotions resulting from the interaction of one's mood with his dysfunctional experiences with his family and those around him over the years (21). Therefore, a person's behavior is not part of these beliefs; however, maladaptive behaviors arise in response to dysfunctional beliefs. When one's beliefs are activated, it becomes the command room of negative self-beliefs and negatively causes bias in information. This causes changing dysfunctional and incompatible beliefs for better performance, changing life patterns and maladaptive coping styles, and providing an environment for learning adaptive skills (19). Studies showed that sexual beliefs, as personal attitudes of individuals, play a decisive role in reducing sexual self-efficacy.

Regarding the limitations of this study, since social beliefs about sexual issues are often negative, and in the minds of the majority of people, they are taboos, they were used only by female patients in sampling, which prevents the generalization of the results of the research to male patients. Furthermore, it was difficult to plan the sexual problems of patients in the presence of their spouses. Therefore, patients participated in treatment sessions alone, which is also one of the limitations of the study. Although the random placement of members in both groups and the use of covariance analysis somewhat moderate the effect of primary differences, it is suggested to use peer groups and reduce primary individual differences in future studies. It is also suggested that the effectiveness of treatment for each sexual dysfunction be examined separately. This means that enough samples of each disorder are selected from the patients and the effectiveness of cognitive-behavioral therapy for each disorder be evaluated, and finally, the results obtained in each disorder be compared with other disorders. Finally, to evaluate the stability of therapeutic effects, it is recommended that follow-up tests be performed at different intervals after the end of the treatment intervention.

Conclusion

The results of this study showed the effect of emotion-focused approach therapy and cognitive-behavioral therapy as supportive methods in increasing sexual self-efficacy in women with breast cancer.

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