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The Effectiveness of Emotion-Focused Therapy on Emotional, Cognitive, Motivational, and Biological Symptoms of Major Depressive Disorder

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Background: Major depressive disorder (MDD) is associated with emotional, motivational, cognitive, behavioral, and biological symptoms. Depressed people have negative emotional experiences and are usually unhappy, frustrated, distressed, impatient, and discouraged.

Objective: This study aimed to determine the effectiveness of emotion-focused therapy on emotional, cognitive, motivational, and biological symptoms of major depressive disorder.

Method: The present study was a quasi-experimental research with pretest, posttest, and follow-up design. The statistical population of the study consisted of all clients referred to the beautiful mind counseling center in Bojnourd in 2019-20, among which 30 people were selected using purposeful sampling method and were assigned to two experimental (n=15) and control (n=15) groups. Data were obtained from a researcher-made depression questionnaire. Data were analyzed using repeated measure analysis of variance and SPSS software (version 24).

Results: The results indicated that emotion-focused couple therapy was effective in reducing emotional symptoms (P<0.01), cognitive (P<0.01), motivational (P<0.01), and biological symptoms (P<0.01) of major depressive disorder.

Conclusion: It can be concluded that emotion-focused couple therapy is effective in reducing emotional, cognitive, motivational, and biological symptoms of people with major depressive disorder and this treatment can be used to improve the problems of depressed individuals.

Keywords: Cognition, Depressive Disorder, Emotion-focused therapy, Emotions, Motivation

Introduction

Major depressive disorder can be diagnosed by a depressed mood or feeling sad and disgusted with any daily effort and pleasure (1). In addition, depressed people suffer from cognitive problems (such as difficulty concentrating, memory, and executive functions) (2). They also have low self-esteem and feel worthless and hopeless (3). Major depressive disorder is associated with emotional, motivational, cognitive, behavioral, and biological (vegetative) symptoms. Depressed people have negative emotional experiences and are usually sad, frustrated, distressed, jolly, and discouraged. Depression is a state of unhappiness that affects daily life, effort, self-evaluation, judgment, and basic actions such as sleep, appetite, and nutrition. These people cry early, and their crying cycles are close and plentiful. They rarely smile or experience positive excitement and pleasantry. They are usually unmotivated (4). They lose interest in activities that they enjoyed before the depression. Some thoughts are strongly associated with major depressive disorder: pessimistic beliefs about their abilities, the world, and the future, thoughts of death and suicide, inability to mindfulness and decision-making, misconceptions, and irrational beliefs that lead to wrong decision-making. Depressed people have sluggish speech and behavior, respond to others with short sentences, are physically inactive, and complain of fatigue, and have bradyphrenia. The subject and the number of their statements are limited. Biological (vegetative) symptoms of major depressive disorder include changes in appetite, weight, constipation, sleep disturbances, and decreased sexual arousal (5).

Biological, psychoanalytic, cognitive, emotional approaches have explained the etiology and treatment of this disorder, but each reveals a corner of reality and they do not necessarily contradict each other. Due to the complexity and multidimensional nature of mental disorders, researchers and psychologists have tried to systematically integrate certain components of different therapeutic approaches in a coherent model that has unique advantages such as broadening intervention and flexibility in the treatment of clients (6). One of these approaches is an experimental treatment called emotion-focused therapy in which "person-centered therapy" of Rogers and "gestalt exercises" of Perls are integrated with "emotional therapy" and "dialectical structural meta-therapy" (7). Emotion-focused therapy is an empirical and integrative approach for treating depression, psychological trauma, and distress. What is discussed in emotion-focused therapy is that emotions have a consistent and adaptive potential that identifies what is important for one's well-being and prepares the individual for adaptive actions (8) so activating them helps clients change their problematic emotional states or unwanted experiences. Emotion-focused therapy is designed as a treatment for depression (9). Emotion-

focused therapy helps clients process their emotional experiences and thereby achieve initial situation-compatible emotional responses to treat depression. Emotional arousal in the middle of treatment, along with a reflection of emotions to understand it, affects the better outcome of treatment (10). They are less likely to relapse in clients who go through deeper emotional reconstruction on fundamental issues, and these people get better results from treatment (10). Ribeiro et al. (11) examined the duality/ambivalence in therapy by focusing on the emotion of depression and showed that clients who move towards new and innovative narratives in this duality and can consolidate new positions and narratives will have better consequences of treatment.

Adopt appropriate methods to identify risk factors, prevention, treatment, and management of depression seems necessary due to the high prevalence and psychological burden that this disease imposes on the individual, health system, and society. Considering the side effects of medication, determining effective psychological therapies is essential to be accepted by individuals. Therefore, researchers should seek effective treatment strategies that are empirically supported. Various non-pharmacological therapies such as cognitive-behavioral therapy and interpersonal therapy which have been reviewed and confirmed, have been proposed in addition to pharmacological therapies. Newer methods have emerged that are more useful than older ones while retaining the benefits of previous therapies. In summary, the effect of emotion-focused therapy on reducing depression symptoms has been neglected by researchers. However, further research is needed to investigate the efficacy of these treatments in clinical psychological disorders.

Objective

This study aimed to determine the effectiveness of emotion-focused therapy on emotional, cognitive, motivational, and vegetative symptoms of major depressive disorder.

Methods

The present study was a quasi-experimental research with pretest, posttest, and follow-up design. The statistical population of this study included all clients referred to the beautiful mind counseling center of Bojnourd in 2019-20 who were diagnosed with major depressive disorder by professional psychiatrists. A total of 30 participants were selected from among the eligible candidates who volunteered to participate in the program after providing the necessary explanations to the therapist. The eligible individuals were selected using the purposeful sampling method and were randomly assigned to two groups (emotion-focused therapy and control). The sample size of this study was determined by referring to Cohen's table (12) and considering the effect size of 0.7, test power of 0.91, and significance level of 0.05. The minimum sample size was 12 people for each group, for which 15 persons were considered according to the fall problem. Voluntary available sampling method was selected and assigned to two groups of emotion-focused therapy (n=15), and control (n=15).

Inclusion criteria included 1) major depressive disorder based on the diagnosis of clinical psychologist and the score of Beck's Depression Inventory (20 and above), 2) having major depressive disorder for at least two weeks, 3) age range of 18 to 55, 4) psychiatric medication, 5) not receiving psychological treatment at the same time with target treatment, 6) having a minimum diploma education and the ability to write and read. Exclusion criteria were any physical disability that prevents effective participation in the treatment program and therapeutic exercises and absence of more than two sessions.

Ethical considerations of the present study included: Before starting work, the participant (volunteer) was informed about the subject and method of the study, then written informed consent was obtained. The personal information of the candidates will be protected. The results were interpreted for them if desired. The necessary guidance for follow-up was provided to the volunteers in case of any disturbances. Participation in the research did not cause any financial burden for the participants. This research does not contradict the religious and cultural standards of the subjects and society. This research is approved by the Ethics Committee of Islamic Azad University, Bojnourd Branch, Bojnourd, Iran (IR.IAU.BOJNOURD.REC.1399.043).

Depression Questionnaire (researcher-made)

This questionnaire has four theoretical components as follows: 1) emotional symptoms component (28 articles), 2) cognitive cues (30 females), 3) motivational symptoms (22 females) and 4) biological symptoms component (plant) (8 materials). Internal consistency of questions of each component showed that the obtained components have high internal consistency. The components of "cognitive cues" with 30 materials and "biological or vegetative", had the highest (0.93) and lowest (0.79) coefficient of similarity, respectively. had the lowest coefficient. Three correlation methods were used between subtests, and the factor analysis method to assess the validity of the depression questionnaire. The total score of each component was constructed considering that the scale consisted of four components in the correlation method between subtests, and then the total score of the scale (80 articles) was calculated. Finally, the correlation coefficient of the components with each other and the total score of the scale was obtained. All correlations between components with each other and components with a total scale score were significant at $P<0.01$. The highest correlation was found between the components of "cognitive symptoms" and the total scale score (r=0.92) and the lowest correlation between components of "motivational symptoms" and "emotional" (r=0.50) and the correlation between biological symptoms and the total scale score (r=0.78). In general, all components with the total scale score

show high and significant correlation coefficients. Also, on the correlation coefficients of the materials with the total score of each category and the total score of the test. This result indicates that subscales have satisfactory internal consistency and no material needs to be removed. Principal component analysis with varimax rotation at the material level was used to evaluate the factor structure (construct validity) of the questionnaire. The sampling adequacy test showed that the sample was suitable for factor analysis (KMO=0.88). Also, the Bartlett spherical test with a degree of freedom of 300=df, and approximate chi-square (χ^2=4.02) levels are significant at p<0001, so factor analysis can be reported. Pebble diagram and specific values higher than one showed that four factors can be extracted. The domain value of subscriptions was 0.51 to 0.81. In total, four factors explain 68% of the variance. Factor 1 with a specific value of 0.11 had the highest percentage of explained variance (43.9%) among the factors. In total, four existing factors explained 68.6 variances of the test, which is a relatively significant percentage. The results after varimax rotation indicate that the specific value of the first factor is 6.81 and therefore is considered as a major factor in factor analysis. In total, four factors explained 68.61% of the variance. The first factor consists of 28 materials with a factorial load range between 0.49 and 0.83 which can be called "emotional symptoms" due to the nature of its questions. The second factor consisted of 30 materials with a factorial load range between 0.42 and 0.76. According to the relevant questions, the second factor can be named "cognitive symptoms". The third factor consisted of 22 materials with a factor load of 0.55 to 0.82. According to the questions of the third factor, it can be referred to as "motivational symptoms". The fourth factor consisted of 8 materials with a factor load of 0.60 to 0.78. According to the questions of the fourth factor, it can be named as "physical symptoms". The results showed that all extracted factor loads were higher than 0.40. The all materials have a correlation of more than 4% based concurrent validity of the questionnaire was assessed through the simultaneous implementation of the Beck depression scale, which was 0.69. The reliability coefficient of emotional, cognitive, motivational, physical symptoms and total score of the scale were 0.79, 0.83, 0.93, and 0.81, respectively, using Cronbach's alpha method. Also, the reliability coefficient for subscales of emotional, cognitive, motivational, physical symptoms and total score of the scale were 0.70, 0.66, 0.73, 0.70, and 0.78, respectively.

After sampling, the subjects were evaluated using research tools in the pre-test stage. Participants were assured that the information would be confidential and anonymous. Emotion-focused group therapy intervention was performed on the experimental group based on the treatment protocol of Greenberg (13) in four 90-minute sessions, once a week. In addition, the control group did not receive any treatment or training during the intervention period and was only on the waiting list of receiving psychological services and counseling.

Data were analyzed using SPSS software (version 24) and two descriptive statistics methods (mean, standard deviation) and inferential statistics of repeated measure analysis of variance at a significant level of 0.05.

Results

The mean (SD) age in the experimental and control groups was 41.8 (7.9) and 42.3 (7.5), respectively. The mean (SD) of research variables in pretest, posttest, and follow-up are presented in Table 1.

Table 1. Mean (SD) of research variables in pretest, posttest, and follow-up

Variable	Group	Pre-test		Post-test		Follow-up	
		M	SD	M	SD	M	SD
Emotional Symptoms	Experimental	57.05	15.52	14.34	11.01	47.75	10.37
	Control	58.45	13.61	57.30	13.63	57.25	13.79
Cognitive Symptoms	Experimental	59.30	15.66	35.05	14.33	54.20	14.97
	Control	58.40	5.04	58.10	5.02	58.00	5.26
Motivational Symptoms	Experimental	42.35	12.87	30.25	10.71	29.40	10.75
	Control	42.60	10.18	41.05	10.19	40.60	10.14
Physical Symptoms	Experimental	21.80	7.38	13.85	5.33	14.05	5.57
	Control	22.65	9.00	20.0	8.83	21.9	8.72

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According to the information obtained from the Kolmogorov–Smirnov test, the z value was not significant for the research variables and it can be concluded that the distribution of data was normal, and the normality of the data is observed and the use of variance analysis test is allowed. The F value of Leven's test (equality of variances) of all variables was not significant at the level of 0.05. Therefore, zero frequency is not rejected and the test is not significant and there is no significant difference between the variances of the scores of the research variables in the experimental and control groups. Therefore, the same assumption (homogeneity) of the variances of the scores of experimental and control groups is confirmed in the research variable, and the assumption of homogeneity of variances has been observed. M box test was used to investigate the default homogeneity of dependent variable quartets (post-test scores) and (follow-up scores) in the two groups. As can be seen above, the default homogeneity of covariances is established in the research variables.

Table 2- Multivariate analysis of variance test results

Effects	Test	Value	F	Df Hypothsis	Df Error	P	Eta^2
Time	Pillai's Trace	0.86	88.95	2	27	0.001	0.86
	Wilks 's Lambda	0.13	88.95	2	27	0.001	0.86
	Hotteling's effect	6.58	88.95	2	27	0.001	0.86
	Roy's largest root	6.58	88.95	2	27	0.001	0.86
Time*Group	Pillai's Effect	0.67	28.43	2	27	0.001	0.67
	Wilks's Lambda	0.32	28.43	2	27	0.001	0.67
	Hotteling's effect	2.1	28.43	2	27	0.001	0.67
	Roy's largest root	2.10	28.43	2	27	0.001	0.67

As can be seen in Table 2, the significance levels of all tests are significant at the level of 0.001, which indicates that there is a significant difference between the mean of the tests in terms of the effectiveness of emotion-focused therapy on improving emotional symptoms in the experimental and control groups. It should be noted that the Wilks's Lambda test with a value of 0.32 and F=28.43 showed a significant difference between the scores of the effectiveness of emotion-focused therapy on improving emotional symptoms in the experimental and control groups at a significant level of 0.001.

Table 3- Repeated measure analysis of variance for comparison of pre-test, post-test, and follow-up in experimental and control groups

Variables	Effect	SS	Df	MS	F	P	Eta^2
Emotional Symptoms	Time	25.62	2	12.81	70.48	0.001	0.71
	Time*group	12.86	2	6.43	35.39	0.001	0.55
	Group	184.40	1	184.40	12.08	0.001	0.21
Cognitive Symptoms	Time	170.60	1.45	117.75	175.61	0.001	0.56
	Time*group	116.86	1.45	80.54	120.30	0.001	0.40

	Group	211.60	1	211.60	27.53	0.001	0.41
Motivational Symptoms	Time	87.62	2	43.81	164.78	0.001	0.85
	Time*group	37.48	2	18.74	70.50	0.001	0.71
	Group	131.61	1	131.61	15.25	0.001	0.24
Physical Symptoms	Time	230.46	1.70	160.14	79.16	0.001	0.73
	Time*group	150.02	1.70	104.24	51.53	0.001	0.64
	Group	418.17	1	418.17	38.86	0.001	0.44

The results of Table 3 indicate that the analysis of variance is significant for the intragroup (time) and intergroup factors. These results mean that considering the effect of the group, the effect of time alone is also significant. Also, the interaction between group and time is significant.

Discussion

This study aimed to determine the effectiveness of emotion-focused therapy on emotional, cognitive, motivational, and biological symptoms of major depressive disorder. The results of the present study were consistent with the research of Ribeiro et al. (11), Cunha et al. (12), Cunha et al. (14). The results were inconsistent with those of Timulak et al. (17).

It can be said that emotion-focused therapy assists people to free themselves of negative thoughts and output new responses by inhibiting negative cycles, activating positive cycles, and strengthening attachment disciplines. As a result, emotional symptoms are reduced and quality of life is improved. As a result, emotional symptoms of major depressive disorder are reduced (17). Emotion is one of the main factors of the attachment approach. Emotional structures help us predict, explain, react and control life experiences. Emotions are not stored in our memory but are revived by evaluating situations that activate a particular emotional framework and lead to a set of private behaviors. During emotion-focused therapy, such situations are redesigned so that people explore and expand their emotions, and then they can refine their emotions during this new experience. The most basic level of emotional functioning is an adaptive form of information processing and readiness that directs the behavior and improves the vegetative symptoms of major depressive disorder. Individual and group emotion-focused therapy in major depressive disorder includes methods based on activation of primary strong emotion which is created in the context of the empathic communication field. This type of treatment also focuses on its emotional organization (18). Emotion-focused therapy reduces the physical symptoms of major depressive disorder by creating high emotional management ability.

In explaining this finding, it can be said that emotion-focused therapy is focused on the principle of "dogma versus flexibility". This technique is dedicated to developing awareness and people's experiences and confronting people's stubborn beliefs, as well as helps people to have flexible attitudes about themselves and others, which improves cognitive cues, thus people perceive others differently from before. Emotional symptoms have a unique and phenomenological nature in emotion-focused therapy and the term design for emotional symptoms is a pragmatic concept. In an activated emotional scheme, alive and revealed experience with body impulses is important (19). The duty of therapists and clients in regulating the emotional process of exploring primary emotions and then reconstructing them is considered. Therefore, the unique aspect of emotional experience is firstly emphasized in this treatment process. The therapist identifies negative interactive cycles that indicate insecure attachment and reconfigures these cycles based on expressing latent attachments, which enables people to create these emotions in safe and loving ways (20). Healthier and newer patterns of interaction are created among individuals by reducing the feeling of insecurity among individuals and increasing their attention to healthy expression of primary emotions. In the second step, the focused therapy of the therapist became more scrutinized; The therapist provided conditions in which people outsource their negative cycles, often through focusing on the latest cognitive symptoms of major depressive disorder.

Attachment theory points to the important role of emotions and emotional communication in organizing communication patterns and the cause of change (21). People seek a secure base to meet their needs. This base is influenced by people's attachment styles. The type of attachment of individuals determines the type of communication pattern through which they convey their emotions. The third treatment which included achieving unknown emotions (which are the substructures of interactive and communication patterns) and primary emotions, validated and reflected secondary reactive emotions (e.g. anger, frustration, the bitterness of comedies) and feelings related to depression and distance, but did not emphasize it (17). The emphasis is on finding the first, infrastructural, and defenseless emotions (such as sadness, fear, and shame) that guide

the behavior of others. In any case, the therapist needed to go through secondary emotions to evoke the first emotions. Finally, it can be said that emotion management improves the motivational symptoms of major depressive disorder through changing communication patterns. In this way, negative emotions are caused by the wrong communication pattern and according to emotion-focused therapy, inappropriate communication pattern causes emotional coldness which can lead to improving motivational symptoms of major depressive disorder (20). Therefore, the relationship between emotions and learning is better understood if the learner's emotional development is taken into consideration.

In explaining this finding, it can be said that emotion-focused therapy is based on experimental and humanistic relationships. Interactions between therapists and the emotional state of the clients predict treatment outcomes. Furthermore, approaching bitter mental and emotional experiences is often an excruciating process for clients. The mission of the therapist in this field is to teach skills to regulate emotion, in addition to creating an efficient relationship. The origins of emotion-focused therapy believe that emotion regulation is a process rather than an educational program with a specific protocol, and in this sense, the therapist's work is more similar to a teacher's work (22). Emotional expression creates personality traits such as high acceptance power and a sense of efficiency, which indicates the existence of desirable cognitive and interpersonal skills. Also, people who express their emotions are more personal, organized, and mentally focused (23). Therefore, emotion-focused therapy encourages emotional expression and improves the way a person deals with emotions, which will have positive effects on the individual's psychological status. Based on emotion-focused therapy, creating safe bonds stabilizes emotional access and responsiveness. In emotion-focused therapy, people are taught to avoid attachment injuries and create a safe relationship for each other. This change improves the biological symptoms of major depressive disorder.

The present study contains some limitations. subjects may be affected by the test conditions due to multiple responses to the questionnaire (pre-test and post-test) and their accuracy in answering has decreased. The variables were measured by self-reporting and the results should be cited carefully that due to a large amount of requested information, some subjects may not have accurately answered the questions or may have subconsciously filled out the questionnaires for self-confirmation. Inability to control variables such as family support or lack of support for people with major depressive disorder is another limitation. The recommendations of the present study were as follows: Other methods of data collection such as interviews and observation should be used in future studies. The present study was conducted cross-sectionally, conducting qualitative and longitudinal research is recommended. It is also suggested that demographic variables such as economic status, religion, religion, and ethnicity be controlled. Future research can also determine the number of group therapy sessions based on the progress of the subjects so that those who make more progress leave treatment sessions sooner and the therapist focuses on the subjects who progress more slowly.

Conclusion

Based on the findings of this study, it can be concluded that group emotion regulation training affects cognitive assessment, death anxiety, experiential avoidance, and emotional expression in nurses.

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