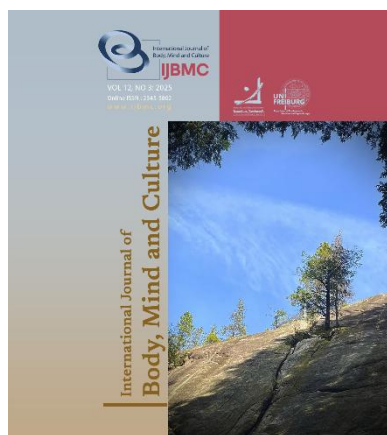


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Introduction

Women are a significant part of society, and their mental health demands considerable attention. Having a sense of hope, vitality, and happiness can significantly impact their functionality and activities, ultimately contributing to the happiness of future generations

Comparative Effects of Emotion-Focused Therapy and Yoga Therapy on Somatic Symptoms and Alexithymia in Depressed Married Women

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ABSTRACT

Objective: This study investigates the comparative effectiveness of EFT and yoga therapy on somatic symptoms and alexithymia in depressed married women.

Methods and Materials: This semi-experimental study employed a pre-test and post-test design with experimental and control groups. A sample of 30 married women aged 20–45 diagnosed with depressive disorder was randomly assigned to three groups: EFT (n = 10), yoga therapy (n = 10), and a control group (n = 10). Participants completed the Beck Depression Inventory, the Paul and Enright Somatic Symptoms Questionnaire, and the Toronto Alexithymia Scale. Interventions were conducted over 12 weekly 90-minute sessions. Data were analyzed using repeated measure analysis of variance and SPSS.16.

Findings: EFT showed greater effectiveness in reducing alexithymia (mean reduction: 39.9%) compared to yoga therapy (27.5%) and the control group (2.1%) ($p < 0.001$). Similarly, somatic symptoms decreased significantly in the EFT group (30.1%) compared to yoga therapy (26.8%) and the control group (0.7%).

Conclusion: EFT demonstrates superior effectiveness in addressing both somatic symptoms and alexithymia in depressed married women. Yoga therapy also provides significant benefits, making both approaches valuable tools for counselors. Integrating these therapies into counseling programs may enhance psychological and marital well-being.

Keywords: Emotion-Focused Therapy, Yoga Therapy, Somatic Symptoms, Alexithymia.

(Davoudi-Monfared et al., 2023; Jamshidi et al., 2024). Depression, recognized as a public health challenge within the social structure of the family, is a stress-inducing phenomenon that doubles individuals'—especially women's—vulnerability to physical and psychological problems (Sauletzhanovna et al., 2024; Shi

et al., 2020). According to the World Health Organization, depression is the second leading cause of disability and functional impairment globally. It is often referred to as the "psychological common cold" due to its high prevalence (Hoshino et al., 2016). This condition is chronic, recurrent, and potentially life-threatening, accompanied by symptoms such as dissatisfaction, loss of previous interests and energy, low self-esteem, feelings of sadness and guilt, appetite changes, and disrupted sleep patterns (Hoshino et al., 2016). Its prevalence among women is approximately twice that of men, with a lifetime prevalence of around 17%—the highest among psychiatric disorders (Bach et al., 2020). Depression leads to personal and familial harm, occupational damage, interpersonal relationship challenges, and a general inability to focus on everyday life (Bach et al., 2020; Buttner et al., 2016).

Women with poor communication patterns often experience significant distress and challenges in emotional regulation and interpersonal relationships, exacerbating their difficulties (Elhai et al., 2017). In fact, recurring issues in regulating emotions, expressing feelings, and empathy are referred to as alexithymia, which also includes difficulties in identifying and describing emotions, distinguishing emotions from bodily arousal sensations, and limited imagination characterized by a lack of fantasy. Additional features such as difficulty processing emotional information, understanding facial expressions, and a lower capacity for empathy are also standard among those with alexithymia. Due to indifference and lack of interest in others, individuals with alexithymia face numerous interpersonal challenges (Alexa et al., 2019). Research indicates that alexithymia is a common issue among women with depressive disorders, contributing to social withdrawal, impulsive behaviors, and emotional problems (Marchesi et al., 2015). The degree of distress and intensity of negative emotions can stem from individual differences, influencing coping strategies, focus, problem-understanding, adaptability, and attitudes toward life (Marchesi et al., 2015).

Yoga is one of the recommended practices for reducing depression (Gallagher et al., 2020; Harvey et al., 2020). Yoga is a mind-body exercise that engages physiological and psychological processes. Its emphasis on relaxation and its static and dynamic exercises distinguish it from conventional methods (Harvey et al.,

2020). Regular yoga practice promotes muscle contraction and relaxation alters breathing patterns, improves focus and mindfulness, enhances heart muscle strength, boosts circulation, reduces muscle tension, increases neurotransmitter levels, and alleviates stress and negative emotions (Bridges & Sharma, 2017). Yoga exercises can also aid in hemispheric lateralization, increased oxygen consumption, brainwave activation, and cognitive improvement (Ensari et al., 2019).

Emotion-focused therapy (EFT) is another therapeutic approach that can reduce depressive symptoms, facilitate better adaptation to challenges, and teach practical methods of regulating emotions and negative moods (Timulak et al., 2018). EFT is a short-term therapy that incorporates experiential, client-centered, constructivist, and systemic perspectives, with attachment theory as its foundation (Timulak et al., 2020). According to this model, emotions possess inherent adaptive capacities that, when activated, can help individuals shift their emotional stances and unwanted emotional expressions (Emami Khotbesara et al., 2024).

Given the prevalence of depression, particularly among women, its long-term consequences on families and children, and the need to identify factors influencing this issue, the researcher seeks to address whether there is a difference in the effectiveness of emotion-focused therapy and yoga therapy on physical symptoms and alexithymia in depressed women.

Methods and Materials

Study Design and Participants

The present study utilized a semi-experimental design with pre-test, post-test, and follow-up assessments, including experimental and control groups. The statistical population comprised all married women aged 20 to 45 diagnosed with depressive disorders by a neurologist or psychiatrist who were referred to psychological counseling centers under the supervision of the Welfare Organization in Chalous during the first nine months of 2020. According to the Welfare Office in Chalous, the total number of these women was 46. From this population, 46 participants were initially selected. Structured interviews assessed depressive disorders, the onset duration of symptoms, and the absence of other psychological disorders. Participants completed the

Beck Depression Inventory (BDI), and 30 women who met the inclusion criteria and scored above one standard deviation above the mean on the BDI were chosen as the sample. These participants were randomly assigned to three groups: Experimental Group 1 (Emotion-Focused Therapy, 10 participants), Experimental Group 2 (Yoga Therapy, 10 participants), and a Control Group (10 participants).

The intervention for Experimental Group 1 consisted of 12 sessions of 90-minute emotion-focused therapy based on Susan Johnson's approach (2004). Similarly, Experimental Group 2 underwent 12 sessions of 90-minute yoga therapy. During this period, the control group was placed on a waiting list. Following the interventions, all participants in the three groups completed the same questionnaires during the post-test phase.

Inclusion Criteria were: Informed consent to participate, ability to attend group therapy sessions, clinical depression diagnosis by a neurologist or psychiatrist, age between 20 and 45 years, education level ranging from high school diploma to master's degree, married status, no simultaneous participation in other therapeutic or educational programs, and Initial screening indicating depressive symptoms. Exclusion criteria were withdrawal from the study and absence from two therapy sessions.

After defining the objectives, appropriate tools were selected, as described in the research tools section. Permission was obtained from the Chalous Welfare Office following the selection of participants. Three specialized clinical counseling centers for depressive disorders were chosen. Eligible women diagnosed with depression by specialists during the first nine months of 2020 were invited to participate. From the initial list of 46 individuals, 30 participants meeting the inclusion criteria were selected and randomly assigned to one of three groups: Experimental Group 1 (Emotion-Focused Therapy), Experimental Group 2 (Yoga Therapy), and the Control Group. Participants attended an orientation session where research objectives were explained, motivation was encouraged, and consent was obtained. All participants completed pre-test assessments. The intervention groups received their respective treatments over 12 sessions of 90 minutes each, while the control group remained on a waiting list. After the intervention phase, all participants completed post-test assessments.

This study adhered to the ethical principles of the Declaration of Helsinki and received approval from the institutional ethics review board. Written informed consent was obtained from all participants, ensuring they were fully aware of the study's objectives, procedures, and their right to withdraw at any time without repercussions. Participant confidentiality was maintained by anonymizing data and securely storing it. The interventions were conducted by trained professionals to ensure safety, and control group participants were offered therapy post-study. The results will be transparently reported, upholding ethical research and publication standards.

Instruments

Demographic Information Form: This form collected data on participants' age, marital status, education level, number of children, and history of depression.

Beck Depression Inventory (BDI): Developed by Beck et al. (1961) and revised in 1999, the BDI consists of 21 items related to depressive symptoms. Responses are scored on a four-point Likert scale (0 to 3), with completion taking approximately 10 minutes. Meta-analyses have shown internal consistency coefficients between 0.73 and 0.93, with a mean of 0.86. Test-retest reliability ranges from 0.48 to 0.86, depending on time intervals and population types (Momeni et al., 2013).

Physical Symptoms Questionnaire: Developed by Powell and Enright (1991), this 18-item questionnaire measures physical symptoms like heart palpitations and dizziness. Responses are scored on a four-point Likert scale (0 to 3), with a reliability coefficient of 0.68 reported for a two-week interval test-retest in Isfahan.

Toronto Alexithymia Scale (TAS-20): Designed by Bagby, Taylor, and Parker (1994), this 20-item test measures three subscales: difficulty identifying feelings, difficulty describing feelings, and externally oriented thinking. Scores are rated on a five-point Likert scale (1 to 5). Internal consistency coefficients range from 0.70 to 0.77 in Farsi translations (Besharat, 2013).

Interventions

Emotion-Focused Therapy (EFT): Based on Susan Johnson's model, EFT was conducted in 12 structured sessions. Each session focused on elements such as

empathic attunement, identifying and processing emotions, and creating a new self-identity. In the first session, the therapist focuses on establishing rapport with the client using advanced empathy techniques by being present, attuned, and responsive to the client's needs, fostering a safe therapeutic environment through understanding, validation, and empathic mirroring. The second session involves exploring the client's presenting problem in depth and beginning to observe their emotional processing patterns, specifically identifying and naming painful emotional experiences. During the third session, the therapist accompanies the client more actively, helping them identify, tolerate, accept, and regulate their emotional responses while observing their unique emotional processing style. The fourth session shifts toward trauma-related work, where the therapist guides the client to access and process attachment-related experiences and the core emotions connected to those memories. In the fifth session, the focus is on differentiating primary, secondary, and instrumental emotions using micro-markers and structured tasks that bring underlying emotions to the surface. The sixth session continues working on core emotions, helping the client further identify and represent these emotions while differentiating between adaptive and maladaptive responses. The seventh session is dedicated to uncovering and working through emotional blocks that hinder access to primary and secondary emotions. In the eighth session, the therapist helps the client connect their current emotional difficulties to internalized object representations, such as those associated with early caregivers or significant past relationships. The ninth session employs expressive art modalities—such as drawing, body movement, music, or somatic work—to process residual images and deepen emotional understanding. The tenth session involves coaching the client through experiential insight while engaging with internalized object representations to shift entrenched emotional patterns. In the eleventh session, the therapist evaluates how the client's construction of new emotional meanings contributes to a developing, more cohesive sense of self. Finally, the twelfth session focuses on consolidating therapeutic gains, helping the client generalize new emotional understandings to future situations, reviewing the overall process, and facilitating an emotionally resonant and reflective closure.

Yoga Therapy: A 12-session yoga program included physical exercises, relaxation techniques, and breathing practices, emphasizing emotional and physiological well-being. The first yoga therapy session begins by introducing group members through rhythmic movement and simple games to establish comfort and engagement, followed by a light warm-up, gentle physical exercises, and ending with a guided relaxation to promote calmness. In the second session, participants review standing, sitting, and sleeping postures with the aid of yoga props to create bodily awareness, complemented by a warm-up and relaxation phase. The third session focuses on breath awareness, with playful exercises aimed at teaching proper abdominal breathing techniques, interspersed with warm-up and ending in relaxation. The fourth session integrates a review of previous techniques, a warm-up, and a Q&A segment where participants express feelings and interests, concluding with relaxation for grounding. The fifth session incorporates warm-up activities followed by attention-enhancing tasks such as walking on a brick path and balancing balloons, supporting focus and ending with deep relaxation. In the sixth session, participants engage in mandala coloring for mindfulness, receive education on healthy eating with a colorful and interactive table setting, and conclude with relaxation. The seventh session fosters socialization through warm-up games and singing activities with coordinated hand movements, leading to a closing relaxation practice. The eighth session emphasizes physical activity with sun salutations, a review of past yoga techniques, a preparatory warm-up, and final relaxation. The ninth session introduces awareness rotation, a practice to improve body focus and relaxation, helping participants tune into bodily sensations more deeply. In the tenth session, participants are guided to shift their attention from external stimuli to internal states through targeted breathing exercises, enhancing introspective focus. The eleventh session offers a comprehensive physical sequence that includes standing, sitting, and lying movements while reinforcing deep relaxation strategies for mind-body integration. The final session, the twelfth, provides a comprehensive summary of all prior activities, encourages participant reflection, facilitates emotional and group closure, and includes post-intervention assessments to evaluate progress.

Data Analysis

Data analysis was conducted in two sections: descriptive and inferential statistics. Descriptive analysis included central tendency measures, frequency distributions, percentages, minimum and maximum values, mean, and standard deviation. The inferential analysis involved the Kolmogorov-Smirnov test in checking the normality of data distribution and Levene's test to assess the homogeneity of variances. Hypotheses were analyzed using repeated measure analysis of variance. All analyses were performed using SPSS version 16.

Findings and Results

Table 1

Mean and standard deviation in experimental and control group

Variables	Group	Pre-test		Post-test		Follow-up	
		M	SD	M	SD	M	SD
Physical Symptoms	Yoga Therapy	44.68	5.12	28.39	3.24	30.56	3.70
	Emotion-Focused Therapy	43.12	5.00	30.18	4.04	33.78	4.19
	Control	42.37	4.56	45.02	5.88	44.16	5.47
Alexithymia	Yoga Therapy	68.32	6.44	49.55	4.27	52.31	4.68
	Emotion-Focused Therapy	68.85	6.80	41.39	3.94	43.55	4.76
	Control	66.50	5.65	67.29	5.99	67.11	5.86

To investigate the significant difference between the scores of physical Symptoms and alexithymia between the three groups of yoga therapy, emotion-focused therapy and control, repeated measure analysis of variance was used. Before repeated measures analysis of variance, the results of Mbox, Mauchly spherical, and Leven tests were evaluated to meet the premises. Since the M-box test was insignificant for any variables, the homogeneity condition of variance-covariance matrices

Among the 30 participants in the study, 10 individuals (33.3%) were in the control group (depressed women who received no intervention), 10 individuals (33.3%) were in the yoga therapy group, and 10 individuals (33.3%) were in the emotion-focused therapy group. Regarding age distribution, 10 participants (33.3%) were in the 31-35 age group, which had the highest frequency, followed by 6 participants (20.0%) in the 36-40 and 41-45 age groups, 5 participants (16.7%) in the 26-30 age group, and 3 participants (10.0%) in the 20-25 age group. Data on the mean and standard deviation of physical symptoms in the pre-test and post-test phases for the three groups are presented in [Table 1](#).

has been adequately observed. Also, the insignificance of none of the variables in the Leven test showed that the equality of the variances between groups was observed, and the variance of dependent variable error was equal in all groups. Finally, Mauchly's sphericity test showed that this test was not significant for physical symptoms and alexithymia. Therefore, the equality assumption of variances within subjects was observed (Mauchly's = 0.86).

Table 2

Repeated measure analysis of variance for physical symptoms and alexithymia

Variables	Source	SS	Df	MS	F	P-value	Eta
Physical Symptoms	Time	43.28	2	21.64	153.21	0.001	0.84
	Time*Group	39.46	2	17.73	139.68	0.001	0.83
	Group	44.10	1	44.10	43.53	0.001	0.44
Alexithymia	Time	93.95	1.60	58.71	152.16	0.001	0.84
	Time*Group	42.75	1.60	26.71	69.24	0.001	0.71
	Group	157.34	1	157.34	52.34	0.001	0.55

The above results indicate that the analysis of variance is significant for the within factor (time) and not

significant for the between factor. These results mean that the time effect alone is significant regardless of the

group effect. The time and the group are also significant. Bonferroni post hoc test was used for pairwise comparison.

Table 3

Bonferroni post hoc test results to compare the physical symptoms and alexithymia

Variables	Group	EFT	Control
Physical Symptoms	Yoga Therapy	2.40*	17.53*
	EFT	-	15.79*
Alexithymia	Yoga Therapy	8.40*	18.53*
	EFT	-	26.34*

*p<0.01

The results of [Table 3](#) show that the scores of physical symptoms and alexithymia in the experimental groups and post-test stages were lower than in the control groups. The results showed that emotion-focused therapy was more effective than yoga therapy in case of physical symptoms and alexithymia.

Discussion and Conclusion

The results indicate that emotion-focused therapy effectively reduces physical symptoms in depressed women. These findings align with the prior ([Ahmadi Bajestani et al., 2018](#); [Alavi et al., 2022](#); [Ardakhani & Seadatee Shamir, 2022](#)).

In explaining the results, it can be stated that emotions play a crucial role in various aspects of life, such as adapting to life changes and stressful events. Emotional regulation is essential for initiating, evaluating, and organizing adaptive behavior while preventing negative emotions and maladaptive behaviors. Emotional regulation encompasses a wide range of biological, social, behavioral, and cognitive processes. It involves strategies that reduce, maintain, or enhance an emotion, influencing how emotions are experienced and expressed. In emotion-focused couple therapy, couples engage in a process where they express attachment fears and needs, fostering the development of secure attachment bonds, which lead to sustainable changes in relationship satisfaction and adaptive emotional responses to situations. Patients with somatic symptom disorders often believe they have an undiagnosed serious illness despite negative lab results. Somatic symptom disorders convert psychological conflicts into physical complaints, causing distress or dysfunction in the individual's life. Although the term "somatic" derives

from the Greek word for "body," these disorders are psychological, as no physical abnormalities exist to justify the complaints.

The results also showed that emotion-focused therapy significantly reduces alexithymia in depressed women. These findings align with prior studies ([Miri & Zahiri, 2024](#); [Shokrolahi et al., 2023](#)).

Emotion-focused therapy involves the therapist establishing an effective relationship with the client and teaching them emotional regulation skills. This therapeutic approach focuses on emotions, helping individuals self-regulate. By emphasizing positive emotions, emotional reconstruction, and finding new meanings for better connections with others, this method enhances psychological well-being and effectively treats alexithymia. Alexithymia is a functional disorder in emotional awareness processes, making it difficult for individuals to label their emotions. It negatively impacts personality processes, leading to withdrawal and cold relationships with others.

Some participants were resistant to answering questionnaire items, potentially affecting the results. The large number of questions and participants' impatience might have influenced their responses. Conducting the study exclusively on women limits generalizability. Additional time and energy were required to explain the research's importance and gain participants' cooperation. The lack of a quiet environment for conducting tests posed challenges, though efforts were made to adhere to test administration standards. Participants should be equipped with the skills taught during the therapy sessions. Future studies should replicate this research in other cities to compare results and examine the influence of environmental factors on the relationship between variables. Future research

should explore the impact of mindfulness training on physical symptoms, alexithymia, and marital communication patterns. Recreational programs that incorporate enjoyment and entertainment should be included in women's schedules to reduce depression effectively. To increase external validity, similar studies should be conducted on both genders. Further research should investigate cultural factors influencing the effectiveness of emotion-focused therapy and yoga therapy.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. Ethical considerations in this study were that participation was entirely optional.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contribute to this study.

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