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The Effectiveness of Emotion-Focused Group Therapy on Functional Resilience and Psychological Vulnerability in Women with Sexual Trauma

Maedeh. Najafi

Department of General Psychology, Faculty of Graduate Studies, Islamic Azad University, Kashan Branch, Kashan, Iran.

Corresponding author email address:
maedehnajafi123@gmail.com

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ABSTRACT

Objective: The present study aimed to examine the effectiveness of emotion-focused group therapy on functional resilience and psychological vulnerability in women with sexual trauma.

Methods and Materials: This quasi-experimental study used a pretest–posttest design with a control group. The sample consisted of 30 women with confirmed sexual trauma in Isfahan who were selected through convenience sampling and randomly assigned to an experimental group and a control group, with 15 participants in each group. The experimental group received 12 sessions of emotion-focused group therapy, held twice weekly for 90 minutes per session, while the control group received no psychological intervention during the study period. Data were collected using the Connor–Davidson Resilience Scale and the Symptom Checklist-90. Data were analyzed using multivariate analysis of covariance and follow-up ANCOVA tests.

Findings: The multivariate analysis showed a significant overall effect of emotion-focused group therapy on the combined outcomes of functional resilience and psychological vulnerability, Wilks' $\Lambda = .44$, $F(2, 25) = 15.65$, $p = .01$, $\eta^2 = .55$. Follow-up ANCOVA results showed that the intervention significantly reduced psychological vulnerability, $F(1, 27) = 12.86$, $p = .01$, $\eta^2 = .32$, and significantly increased functional resilience, $F(1, 27) = 14.88$, $p = .01$, $\eta^2 = .35$.

Conclusion: Emotion-focused group therapy was effective in reducing psychological vulnerability and improving functional resilience in women with sexual trauma. These findings support the use of emotion-focused group interventions in trauma-related psychological care.

Keywords: Sexual trauma; Emotion-focused group therapy; Functional resilience; Psychological vulnerability; Women.

Introduction

Sexual trauma is one of the most severe forms of interpersonal trauma and can have long-lasting consequences for psychological, emotional, interpersonal, and social functioning. Exposure to sexual violence may disrupt the survivor's sense of safety, trust, bodily integrity, and self-worth, and it is frequently associated with symptoms such as anxiety, depression, shame, intrusive memories, emotional numbing, avoidance, and posttraumatic stress. Trauma is commonly understood as exposure to actual or threatened death, serious injury, or sexual violence, and sexual trauma is particularly significant because it directly violates personal boundaries and may affect both immediate and long-term mental health outcomes (Association, 2022; Yuan et al., 2006). The present study focused on women with confirmed sexual trauma and examined the effectiveness of emotion-focused group therapy on functional resilience and psychological vulnerability.

The psychological consequences of sexual trauma are not limited to posttraumatic stress symptoms. Survivors may experience disturbances in emotional regulation, interpersonal relationships, body image, self-concept, and overall psychological adjustment. Research has shown that women who experience sexual trauma may report higher levels of psychological distress, social withdrawal, fear, confusion, sleep disturbance, depression, and anxiety. These symptoms can persist long after the traumatic event and may interfere with educational, occupational, family, and intimate relationships. Therefore, sexual trauma should be understood as a multidimensional experience that can increase psychological vulnerability and reduce adaptive functioning over time (Mengo & Black, 2016; O'Callaghan et al., 2019; Yuan et al., 2006).

Psychological vulnerability refers to a person's susceptibility to emotional distress, maladaptive responses, and psychological symptoms when facing stressful or threatening experiences. From the vulnerability–stress perspective, traumatic experiences may activate or intensify pre-existing vulnerabilities and increase the likelihood of anxiety, depression, somatization, interpersonal sensitivity, and other psychological symptoms. In survivors of sexual trauma, psychological vulnerability may be reflected in persistent emotional distress, reduced coping capacity, intrusive thoughts, avoidance, and difficulty maintaining stable functioning. The Symptom Checklist-90 has been widely used to assess broad psychological symptoms and psychological distress across multiple domains, including somatization, depression, anxiety, interpersonal sensitivity, hostility, phobic anxiety, paranoid ideation, and psychoticism (Derogatis, 1983; Derogatis & Kathryn, 2000).

In contrast to psychological vulnerability, functional resilience refers to the capacity to adapt positively in the face of adversity, recover from stressful experiences, and maintain or regain psychological functioning after trauma. Resilience does not mean the absence of distress; rather, it reflects the ability to continue functioning, use internal and external resources, and move toward recovery despite exposure to severe stress. In trauma-related contexts, resilience is considered an important protective factor because it can reduce the negative effects of traumatic experiences and support adaptive coping, emotional stability, and social functioning. The Connor–Davidson Resilience Scale is one of the most widely used instruments for assessing resilience in clinical and research settings and has demonstrated validity for evaluating resilience as a treatment-related outcome (Connor & Davidson, 2003).

Sexual trauma can weaken resilience by disrupting emotion processing and increasing avoidance of painful emotional experiences. Survivors may attempt to manage overwhelming emotions through suppression, dissociation, withdrawal, or avoidance; however, these strategies may maintain psychological vulnerability over time. When traumatic emotions remain unprocessed, they can continue to influence the survivor's sense of self, interpersonal relationships, and ability to cope with future stressors. Therefore, interventions that help survivors identify, experience, regulate, and transform painful emotions may be especially relevant for reducing psychological vulnerability and increasing functional resilience.

Emotion-focused therapy is a humanistic-experiential approach that emphasizes the central role of emotion in psychological functioning and therapeutic change. This approach assumes that emotions provide important information about needs, goals, pain, and relational experiences. Psychological problems may emerge when individuals avoid, suppress, or become overwhelmed by

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emotional experiences. In therapy, clients are helped to become aware of emotions, symbolize them in words, regulate emotional arousal, transform maladaptive emotions, and construct new meanings from painful experiences. Emotion-focused therapy has been applied to different forms of psychological distress and has been developed specifically for complex trauma, where unresolved painful emotions, shame, fear, and self-blame are often central therapeutic targets (Greenberg, 2010; Paivio et al., 2010).

In the context of sexual trauma, emotion-focused therapy may be particularly useful because many trauma-related symptoms are maintained by unprocessed emotional pain. Survivors may carry intense shame, fear, anger, grief, guilt, or helplessness. Emotion-focused therapy does not view these emotions merely as symptoms to be eliminated; rather, it treats them as meaningful experiences that can be explored, regulated, and transformed. By helping survivors approach emotions safely and gradually, the therapy may reduce avoidance, increase emotional awareness, and support the development of more adaptive self-understanding. This process can reduce psychological vulnerability and strengthen resilience by enabling survivors to relate to themselves and their experiences with greater clarity, compassion, and agency (Greenberg, 2010; Paivio et al., 2010).

The group format of emotion-focused therapy can also be clinically meaningful for women with sexual trauma. Sexual trauma is often accompanied by shame, secrecy, isolation, and fear of judgment. A structured therapeutic group can provide a safe relational context in which survivors experience validation, emotional support, universality, and interpersonal connection. Group therapy may help participants recognize that their emotional reactions are understandable responses to trauma rather than signs of personal weakness. Through shared emotional processing and supportive group interaction, participants may increase self-acceptance, reduce isolation, and develop more adaptive coping responses. These mechanisms are directly relevant to increasing functional resilience and reducing psychological vulnerability.

Although different trauma-focused interventions have been used for survivors of sexual trauma, interventions that directly target emotional processing remain especially important. Sexual trauma often damages the survivor's relationship with emotions, body, self, and others. Therefore, treatment approaches that focus only on symptom reduction may be insufficient if they do not address the emotional meanings and unresolved affective experiences associated with trauma. Emotion-focused group therapy may offer a useful pathway by combining emotional awareness, emotional regulation, interpersonal support, and meaning reconstruction within a therapeutic group context.

Accordingly, the present study aimed to examine the effectiveness of emotion-focused group therapy on functional resilience and psychological vulnerability in women with sexual trauma. It was expected that participation in emotion-focused group therapy would increase functional resilience and reduce psychological vulnerability by helping participants process traumatic emotional experiences, regulate distress, and develop more adaptive responses to themselves and others.

Methods and Materials

Study Design

The present study used an applied, quasi-experimental design with a pretest–posttest control group. The independent variable was emotion-focused group therapy, and the dependent variables were functional resilience and psychological vulnerability. Participants were assigned to two groups: an experimental group that received emotion-focused group therapy and a control group that received no psychological intervention during the study period. Both groups completed the research measures before and after the intervention. This design made it possible to examine the effectiveness of the intervention by comparing posttest scores between the two groups while considering baseline differences.

Participants and Sampling Procedure

The statistical population consisted of women with sexual trauma in Isfahan. Participants were recruited from counseling centers, psychotherapy clinics, and psychiatric treatment centers in different areas of Isfahan. Eligible participants were those whose experience of at least one sexual traumatic event had been confirmed by a psychiatrist, psychologist, or counselor at the treatment center. A total of 30 participants were selected through convenience

sampling and then randomly assigned to the experimental and control groups, with 15 participants in each group.

Before entering the study, the general purpose and procedure of the research were explained to the participants, and their consent to participate was obtained. After recruitment, participants completed the pretest measures. The experimental group then received the emotion-focused group therapy intervention, whereas the control group did not receive any psychological intervention during the same period. To maintain motivation and ethical fairness, participants in the control group were informed that they could receive the training program free of charge after completion of the study.

Measures

Data were collected using standardized self-report instruments. A demographic information form was used to collect participants' age, educational level, and employment status. Functional resilience was assessed using the Connor–Davidson Resilience Scale, developed by Connor and Davidson in 2003. In this study, the questionnaire was introduced as a 26-item measure scored on a 5-point Likert scale. The scale assesses resilience through several components, including personal competence and strength, trust in personal instincts, tolerance of negative affect, control, and spirituality. Higher scores indicate greater functional resilience. Previous Iranian research reported acceptable validity for this instrument, including a significant correlation with the Ahvaz Psychological Hardiness Scale, $r = .64$, $p < .0001$.

Psychological vulnerability was measured using the Symptom Checklist-90. The SCL-90 is a self-report measure designed to assess a broad range of psychological symptoms and distress. In the present study, psychological vulnerability was operationally defined as the score obtained from the SCL-90. The measure was used to evaluate psychological symptoms related to vulnerability among participants before and after the intervention.

Intervention

The experimental group received emotion-focused group therapy based on a protocol adapted from Greenberg and colleagues. The intervention consisted of 12 sessions, held twice per week, with each session lasting 90 minutes. The general aim of the intervention was to help participants identify, experience, regulate, and transform painful emotions associated with sexual trauma. The intervention was delivered in a group format and included therapeutic processes such as emotional awareness, empathic validation, alliance building, exploration of emotional experiences, regulation of distress, and development of more adaptive emotional and interpersonal responses.

The first session focused on introducing the group members and therapist, explaining the goals and structure of treatment, clarifying participants' expectations, presenting the basic concepts of emotion-focused therapy, becoming familiar with participants' problems, and administering the pretest. The second session focused on developing empathy and therapeutic alliance, clarifying therapeutic goals, explaining the treatment process, understanding the formation of current relational and emotional problems, and using an ice-breaking exercise to facilitate group engagement.

Across the remaining sessions, the intervention emphasized identifying core emotional experiences, differentiating primary and secondary emotions, recognizing maladaptive emotional responses, reducing emotional avoidance, increasing tolerance of painful affect, and facilitating emotional expression within a safe group context. Participants were guided to reflect on traumatic emotional experiences, understand the meanings of their emotions, and develop healthier ways of responding to themselves and others. The final sessions focused on consolidating therapeutic gains, strengthening adaptive emotional responses, reviewing learned skills, and preparing participants to maintain changes after the intervention.

Procedure

After obtaining the required permissions and coordinating with counseling and psychotherapy centers, eligible participants were identified and invited to participate. Participants who met the inclusion criteria and provided informed consent were assigned to the experimental or control group. At the pretest stage, participants in both groups completed the demographic questionnaire, the Connor–Davidson Resilience Scale, and the SCL-90. The experimental group then participated in 12 sessions of emotion-focused group therapy, while the control group received no intervention. After the intervention period, both groups

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completed the posttest measures under similar conditions.

Inclusion and Exclusion Criteria

The main inclusion criterion was having a history of at least one sexual traumatic experience confirmed by a psychiatrist, psychologist, or counselor at the treatment center. Participants were also required to be willing to participate in the study and complete the assessment measures. Participants who were unwilling to continue participation, failed to attend the intervention sessions regularly, or did not complete the posttest measures were excluded from the study. The use of professional confirmation of trauma history was intended to ensure that participants met the central clinical condition required for participation.

Ethical Considerations

Ethical principles were observed throughout the study. Participation was voluntary, and participants were informed about the purpose of the study, the intervention process, confidentiality of information, and their right to withdraw from the study. Because the study involved women with sexual trauma, attention was paid to emotional safety, privacy, and respectful communication during recruitment, assessment, and intervention sessions. Participants' information was kept confidential and used only for research purposes. The control group was assured that the intervention program would be made available to them after completion of the study.

Data Analysis

Data were analyzed using SPSS version 21. Descriptive statistics, including frequency, percentage, mean, and standard deviation, were used to summarize demographic characteristics and study variables. Before testing the hypotheses, the assumptions required for parametric analyses were examined. The Shapiro–Wilk test was used to assess normality, Box's M test was used to examine equality of covariance matrices, and Levene's test was used to evaluate homogeneity of error variances. Multivariate analysis of covariance was used to examine the overall effect of emotion-focused group therapy on psychological vulnerability and functional resilience, and analysis of covariance was used to test the intervention effects on each dependent variable separately.

Findings and Results

The study included 30 women with sexual trauma who were assigned to an experimental group and a control group, with 15 participants in each group. Most participants were younger than 25 years old; 36.7% were between 15 and 20 years old and 43.3% were between 21 and 25 years old. Regarding education, 53.3% had less than a high school diploma and 30.0% had a high school diploma. In terms of employment status, 86.7% were employed and 13.3% were unemployed.

Before testing the hypotheses, the assumptions of parametric analysis were examined. The Shapiro–Wilk test showed that the distributions of psychological vulnerability and functional resilience scores were normal in both groups at pretest and posttest. Box's M test was not significant, Box's M = 1.72, $F = 0.53$, $p = .66$, indicating that the assumption of equality of covariance matrices was met. Levene's test was also not significant for psychological vulnerability, $F(1, 28) = 0.29$, $p = .59$, and functional resilience, $F(1, 28) = 1.13$, $p = .29$, confirming the homogeneity of error variances.

Table 1 presents the means and standard deviations of psychological vulnerability and functional resilience by group and measurement stage. As shown, the experimental group showed a decrease in psychological vulnerability from pretest to posttest, whereas the control group showed almost no change. In addition, functional resilience increased in the experimental group after the intervention, while the control group showed a slight decrease.

Table 1

Means and Standard Deviations of Psychological Vulnerability and Functional Resilience by Group and Time

Variable	Group	Pretest M (SD)	Posttest M (SD)
Psychological vulnerability, GSI	Experimental	1.25 (0.24)	1.13 (0.10)
Psychological vulnerability, GSI	Control	1.23 (0.13)	1.24 (0.09)
Functional resilience	Experimental	70.73 (4.11)	74.86 (3.75)
Functional resilience	Control	72.40 (3.33)	71.00 (4.12)

The descriptive findings showed that the experimental group had lower psychological vulnerability scores at posttest compared with the control group. The same pattern was observed for functional resilience, where the experimental group showed higher posttest scores than the control group. These descriptive changes indicate that emotion-focused group therapy was associated with reduced psychological vulnerability and increased functional resilience.

A multivariate analysis of covariance was conducted to examine the overall effect of emotion-focused group therapy on the combined dependent variables of psychological vulnerability and functional resilience. The results indicated a significant multivariate effect of group, Wilks' $\Lambda = .44$, $F(2, 25) = 15.65$, $p = .01$, $\eta^2 = .55$. The same significant result was observed across Pillai's Trace, Hotelling's Trace, and Roy's Largest Root. These findings indicate that, after controlling for pretest scores, the experimental and control groups differed significantly in the combined posttest scores of psychological vulnerability and functional resilience.

Table 2

Multivariate Analysis of Covariance for Psychological Vulnerability and Functional Resilience

Test	Value	F	Hypothesis df	Error df	p	η^2
Pillai's Trace	.55	15.65	2	25	.01	.55
Wilks' Lambda	.44	15.65	2	25	.01	.55
Hotelling's Trace	1.25	15.65	2	25	.01	.55
Roy's Largest Root	1.25	15.65	2	25	.01	.55

Follow-up ANCOVA results showed a significant group effect for psychological vulnerability after adjusting for pretest scores, $F(1, 27) = 12.86$, $p = .01$, $\eta^2 = .32$. This result indicates that emotion-focused group therapy significantly reduced psychological vulnerability in women with sexual trauma. The effect size showed that 32% of the variance in posttest psychological vulnerability scores was attributable to group membership. The ANCOVA result for functional resilience was also significant, $F(1, 27) = 14.88$, $p = .01$, $\eta^2 = .35$. This finding indicates that emotion-focused group therapy significantly increased functional resilience. The effect size showed that 35% of the variance in posttest functional resilience scores was explained by group membership.

Table 3

ANCOVA Results for Psychological Vulnerability and Functional Resilience

Dependent variable	Source	SS	df	MS	F	p	η^2
Psychological vulnerability	Pretest	0.06	1	0.06	6.82	.01	.20
Psychological vulnerability	Group	0.10	1	0.10	12.86	.01	.32
Functional resilience	Pretest	119.19	1	119.19	10.20	.01	.27
Functional resilience	Group	173.85	1	173.85	14.88	.01	.35

Additional ANCOVA analyses were conducted for the components of psychological vulnerability. The results showed significant group differences in somatization, $F(1, 27) = 4.33$, $p = .04$, $\eta^2 = .13$; interpersonal sensitivity, $F(1, 27) = 7.71$, $p = .01$, $\eta^2 = .22$; depression, $F(1, 27) = 7.17$, $p = .01$, $\eta^2 = .21$; anxiety, $F(1, 27) = 4.34$, $p = .04$, $\eta^2 = .14$; and phobic anxiety, $F(1, 27) = 4.43$, $p = .04$, $\eta^2 = .14$. However, the effects were not significant for obsessive-compulsive symptoms, hostility, paranoid ideation, and psychoticism.

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Table 4

ANCOVA Results for Components of Psychological Vulnerability

Component	F	p	η^2	Result
Somatization	4.33	.04	.13	Significant
Obsessive-compulsive symptoms	2.99	.09	.10	Not significant
Interpersonal sensitivity	7.71	.01	.22	Significant
Depression	7.17	.01	.21	Significant
Anxiety	4.34	.04	.14	Significant
Hostility	2.53	.12	.08	Not significant
Phobic anxiety	4.43	.04	.14	Significant
Paranoid ideation	0.21	.64	.01	Not significant
Psychoticism	2.30	.14	.08	Not significant

Overall, the findings showed that emotion-focused group therapy had a significant effect on the combined outcomes of psychological vulnerability and functional resilience. The intervention significantly reduced psychological vulnerability and significantly increased functional resilience in women with sexual trauma. At the component level, the treatment significantly reduced somatization, interpersonal sensitivity, depression, anxiety, and phobic anxiety. These results support the effectiveness of emotion-focused group therapy as an intervention for improving resilience and reducing psychological vulnerability in women with sexual trauma.

Discussion and Conclusion

The present study aimed to examine the effectiveness of emotion-focused group therapy on functional resilience and psychological vulnerability in women with sexual trauma. The findings showed that emotion-focused group therapy had a significant effect on the combined outcomes of functional resilience and psychological vulnerability. After controlling for pretest scores, women who received the intervention showed significantly higher functional resilience and significantly lower psychological vulnerability compared with the control group. These findings indicate that a structured emotion-focused group intervention can help women with sexual trauma improve adaptive functioning and reduce psychological distress.

The first finding showed that emotion-focused group therapy significantly reduced psychological vulnerability. This result suggests that women who participated in the intervention experienced lower overall psychological distress after treatment. This finding is consistent with the theoretical foundation of emotion-focused therapy, which emphasizes that unresolved, avoided, or maladaptively processed emotions can maintain psychological symptoms. In trauma survivors, painful emotional experiences such as fear, shame, guilt, anger, helplessness, and grief may remain unprocessed and continue to influence psychological functioning. Emotion-focused therapy helps individuals approach these emotions safely, symbolize them in words, regulate emotional arousal, and transform maladaptive emotional responses into more adaptive emotional meanings (Greenberg, 2010; Paivio et al., 2010).

This finding can also be explained by the emotional nature of sexual trauma. Sexual trauma often involves violation, loss of safety, humiliation, helplessness, and disruption of trust. These experiences may increase psychological vulnerability by producing intrusive memories, avoidance, hyperarousal, self-blame, interpersonal fear, and negative beliefs about the self and others. Emotion-focused group therapy may reduce such vulnerability by providing a safe therapeutic context in which participants can identify and process trauma-related emotions rather than avoid or suppress them. Through emotional awareness, empathic reflection, validation, and expression of primary emotions, participants may become more able to understand their emotional reactions and reduce the intensity of psychological symptoms.

The results also showed that emotion-focused group therapy significantly improved functional resilience. This finding means that participants in the intervention group became more capable of coping with adversity, recovering from psychological stress, and maintaining adaptive functioning. Resilience is not simply the absence of trauma-related symptoms; rather, it refers to the capacity to adapt positively despite exposure to severe stress or adversity. In women with sexual trauma,

resilience may be strengthened when individuals regain a sense of agency, emotional control, self-worth, and connection with others. The findings are consistent with the view that resilience can be developed through therapeutic processes that enhance emotional processing, meaning-making, and adaptive coping (Connor & Davidson, 2003; Southwick et al., 2014).

Emotion-focused group therapy may increase resilience through several mechanisms. First, it helps individuals become aware of emotions and understand the needs embedded in emotional experiences. Second, it encourages the expression of previously avoided or suppressed emotions in a safe context. Third, it helps clients transform maladaptive emotions such as shame, fear, or self-blame into adaptive emotions such as assertive anger, self-compassion, grief, and protective sadness. Fourth, the group format provides interpersonal support, reduces isolation, and creates opportunities for participants to experience acceptance and validation. These mechanisms may strengthen coping capacity and increase functional resilience in women with sexual trauma (Greenberg, 2010; Paivio et al., 2010).

At the component level, the findings indicated that emotion-focused group therapy significantly reduced somatization, interpersonal sensitivity, depression, anxiety, and phobic anxiety. The reduction in somatization may be explained by the close relationship between unprocessed emotional distress and bodily symptoms. Survivors of sexual trauma may experience psychological pain through bodily complaints, tension, fatigue, pain, or autonomic arousal. By helping participants identify and express emotions, emotion-focused group therapy may reduce the need for emotional distress to be expressed somatically. This is consistent with the broader view that trauma-related emotional processing can reduce both psychological and bodily manifestations of distress.

The significant reduction in interpersonal sensitivity is also theoretically meaningful. Sexual trauma can deeply affect trust, intimacy, boundaries, and perceptions of others. Survivors may become highly sensitive to rejection, criticism, judgment, or interpersonal threat. In a therapeutic group, participants can experience supportive relationships, empathic responses, and nonjudgmental listening. These experiences may challenge trauma-related interpersonal expectations and reduce sensitivity to interpersonal threat. In this way, the group format may be particularly useful for women with sexual trauma because it provides a corrective relational experience in addition to emotional processing.

The reduction in depression may be related to the intervention's effect on shame, helplessness, and negative self-evaluation. Depression after sexual trauma may be maintained by self-blame, perceived loss of worth, emotional withdrawal, and unresolved grief. Emotion-focused therapy helps clients access and process painful emotions and develop more compassionate and adaptive meanings. When participants are able to express grief, anger, and unmet needs in a safe therapeutic environment, depressive symptoms may decrease. This explanation is consistent with emotion-focused therapy models, which emphasize the transformation of maladaptive emotions into more adaptive emotional responses as a central mechanism of therapeutic change (Greenberg, 2010).

The significant reduction in anxiety and phobic anxiety may be explained by decreased avoidance and increased emotional tolerance. Trauma survivors often avoid reminders of the traumatic event because such reminders activate fear and distress. However, avoidance tends to maintain anxiety over time. Emotion-focused group therapy encourages gradual and regulated engagement with emotional experience. By learning to tolerate and process painful emotions rather than avoid them, participants may experience reduced fear and greater emotional mastery. This process can help reduce general anxiety and fear-based avoidance.

However, the intervention did not significantly reduce obsessive-compulsive symptoms, hostility, paranoid ideation, or psychoticism. One possible explanation is that these symptom domains may require more specialized or longer-term interventions. For example, obsessive-compulsive symptoms may be maintained by rigid cognitive patterns and compulsive behaviors that require targeted cognitive-behavioral techniques. Hostility may require specific anger-management and interpersonal regulation strategies. Paranoid ideation and psychoticism may reflect more severe or complex psychological processes that are less responsive to a brief group intervention. Therefore, although emotion-focused group therapy was effective in reducing several

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central dimensions of psychological vulnerability, it may not be sufficient for all symptom domains.

The overall pattern of findings supports the idea that emotion-focused group therapy is especially effective for trauma-related symptoms that are closely tied to emotional pain, avoidance, fear, shame, interpersonal insecurity, and depressive distress. Sexual trauma frequently produces emotional injuries that remain active in the survivor's psychological life. When these emotions are avoided, suppressed, or left unprocessed, they may contribute to persistent vulnerability. Emotion-focused therapy directly targets these emotional processes and may therefore be well suited for women with sexual trauma.

The group format may have strengthened the effectiveness of the intervention. Sexual trauma is often accompanied by secrecy, isolation, shame, and fear of disclosure. In a supportive therapeutic group, participants may discover that their emotional reactions are understandable and that they are not alone in their suffering. This sense of universality can reduce shame and increase hope. Group members may also learn from one another's coping strategies and observe emotional expression modeled by others. These group processes may contribute to both reduced psychological vulnerability and increased functional resilience.

From a clinical perspective, these findings suggest that emotion-focused group therapy can be used as a useful intervention for women with sexual trauma, particularly when treatment goals include improving resilience and reducing psychological distress. The intervention may be especially beneficial in counseling centers, trauma services, and community-based mental health settings where group-based interventions can increase access to psychological care. Because sexual trauma may affect several areas of functioning, interventions that combine emotional processing with interpersonal support may be particularly valuable.

Conclusion

The findings of the present study showed that emotion-focused group therapy significantly reduced psychological vulnerability and increased functional resilience in women with sexual trauma. The intervention had a significant overall effect on the combined dependent variables and produced meaningful changes in both main outcomes. At the symptom level, emotion-focused group therapy significantly reduced somatization, interpersonal sensitivity, depression, anxiety, and phobic anxiety, although it did not significantly affect obsessive-compulsive symptoms, hostility, paranoid ideation, or psychoticism.

Overall, the results indicate that emotion-focused group therapy is an effective approach for improving psychological adjustment in women with sexual trauma. By helping participants identify, express, regulate, and transform painful emotions, this intervention can reduce emotional distress and strengthen adaptive coping. The group format may also reduce shame and isolation by providing validation, support, and corrective interpersonal experiences. Therefore, emotion-focused group therapy can be considered a useful psychological intervention for women who experience psychological vulnerability and reduced resilience following sexual trauma.

Practical Implications

The results have several practical implications. First, mental health professionals working with women who have experienced sexual trauma should assess both psychological vulnerability and functional resilience, because treatment should aim not only to reduce symptoms but also to strengthen adaptive capacities. Second, emotion-focused group therapy can be incorporated into trauma-focused treatment programs in counseling centers, psychotherapy clinics, and community mental health settings. Third, group interventions may be especially useful for survivors who experience shame, isolation, and difficulty expressing emotions. Finally, therapists should pay particular attention to emotional awareness, emotional expression, regulation of arousal, self-compassion, and transformation of maladaptive emotions when working with sexual trauma survivors.

Limitations

This study had several limitations. First, the sample size was relatively small, with 15 participants in each group, which may limit the generalizability of the findings. Second, participants were selected through convenience sampling from counseling and treatment centers in Isfahan; therefore, the results may not be generalizable to all women with sexual trauma or to survivors who do not seek psychological services. Third, the study used a pretest–posttest design without a follow-up assessment, so the long-term stability of

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treatment effects could not be determined. Fourth, the data were collected using self-report questionnaires, which may be influenced by response bias, emotional state, or social desirability. Finally, the study focused on women, and the findings may not be generalizable to men or other gender groups who have experienced sexual trauma.

Suggestions for Future Research

Future studies are recommended to use larger samples and randomized controlled trial designs to strengthen the evidence for the effectiveness of emotion-focused group therapy in sexual trauma populations. It is also suggested that future research include follow-up assessments to examine whether treatment effects remain stable over time. Future studies may compare emotion-focused group therapy with other trauma-focused interventions, such as trauma-focused cognitive-behavioral therapy, eye movement desensitization and reprocessing, acceptance and commitment therapy, or compassion-focused therapy. In addition, future research could examine mediating mechanisms such as emotional awareness, shame reduction, self-compassion, interpersonal trust, and emotional regulation to clarify how emotion-focused group therapy improves resilience and reduces psychological vulnerability.

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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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