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Development, Validation, and Effectiveness of an Integrative Counseling Package Based on Emotion-Focused Therapy and Positive Psychology for Trauma-Exposed Women Heads of Household

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A B S T R A C T

Objective: This study aimed to develop and validate an integrative counseling package based on Emotion-Focused Therapy and positive psychology and to evaluate its effectiveness in improving emotional self-regulation, reducing emotional inhibition, enhancing character strengths, and promoting posttraumatic growth among trauma-exposed women heads of household.

Methods and Materials: This developmental-applied study employed a sequential exploratory mixed-methods design. In the qualitative phase, 14 trauma-exposed women heads of household were selected through purposive sampling and interviewed using semi-structured interviews. The data were analyzed through thematic analysis, and the initial integrative package was developed by combining the qualitative findings with theoretical principles of Emotion-Focused Therapy and positive psychology. Content validity was evaluated by 10 experts using the Content Validity Index and Content Validity Ratio. In the quantitative phase, 72 eligible women were randomly allocated to four groups consisting of Emotion-Focused Therapy, positive psychology, integrative intervention, and control. Following attrition, data from 60 participants, 15 per group, were analyzed. The three interventions consisted of 10 group sessions of 90 minutes. Assessments were conducted at pretest, posttest, and three-month follow-up using measures of emotional self-regulation, emotional inhibition, character strengths, and posttraumatic growth. Data were analyzed using ANCOVA, repeated-measures multivariate analysis, and Bonferroni post hoc comparisons in SPSS 27.

Findings: Content validation supported the acceptability of the developed package, with a mean CVI of 0.86 and a mean CVR of 0.78. ANCOVA showed significant posttest differences among the four groups in emotional self-regulation, $F(3,55) = 31.20$, $p < .001$, $\eta^2 = .64$; emotional inhibition, $F(3,55) = 29.70$, $p < .001$, $\eta^2 = .62$; character strengths, $F(3,55) = 42.80$, $p < .001$, $\eta^2 = .70$; and posttraumatic growth, $F(3,55) = 45.10$, $p < .001$, $\eta^2 = .71$. Bonferroni comparisons indicated that the integrative intervention significantly outperformed the other three conditions across all outcomes, while EFT was more effective than positive psychology for

emotion-related outcomes and positive psychology was more effective than EFT for character strengths and posttraumatic growth.

Conclusion: The validated integrative counseling package combining Emotion-Focused Therapy and positive psychology appears to be an effective intervention for simultaneously improving emotional functioning and strengthening positive psychological resources in trauma-exposed women heads of household.

Keywords: *Emotion-Focused Therapy, Positive Psychology, Trauma, Women Heads of Household, Emotional Self-Regulation, Emotional Inhibition, Character Strengths, Posttraumatic Growth*

1. Introduction

Women who assume responsibility for the economic, social, and emotional management of their households constitute a particularly important population in social and psychological research because household headship often occurs in the context of major life disruptions such as divorce, widowhood, abandonment, disability of a spouse, or other destabilizing events. In addition to assuming responsibility for income generation, parenting, household management, and decision-making, many women heads of household must cope with diminished social support, economic insecurity, occupational instability, role overload, and concerns regarding the future of their children. In Iran, the empowerment of women heads of household has consequently become an important psychosocial and welfare-related priority. A systematic review of empowerment-related studies in this population has shown that their difficulties are multidimensional and extend beyond financial vulnerability to include psychological, interpersonal, social, and structural domains, suggesting that effective interventions should address both internal psychological resources and the environmental demands associated with household headship (Zamani Moghadam & Afshani, 2021). Evidence from psychosocial interventions further indicates that empowerment-oriented programs can improve psychological well-being, quality of life, and social functioning among women heads of household, emphasizing the importance of interventions that strengthen their adaptive capacities rather than focusing exclusively on deficits and distress (Rezaeian et al., 2018; Torabi Momen et al., 2017).

The psychological burden associated with female household headship may become substantially more complex when it is accompanied by a history of trauma. Trauma can include childhood maltreatment, interpersonal violence, sexual trauma, loss, abandonment, chronic relational insecurity, and other experiences that overwhelm an individual's capacity to regulate affect and maintain a coherent sense of safety. Such experiences may continue to influence emotional functioning long after the original event has ended. Women exposed to trauma may experience heightened emotional reactivity, avoidance of painful internal experiences, shame, self-criticism, difficulties identifying and communicating emotions, interpersonal mistrust, and persistent expectations of threat. These difficulties may be particularly consequential among women heads of household because they are simultaneously expected to maintain parental, occupational, and caregiving roles while managing their own unresolved emotional experiences. Recent evidence regarding women with histories of interpersonal violence has demonstrated that structured psychotherapy can produce meaningful and sustained improvements in psychological functioning, supporting the importance of trauma-informed interventions tailored to women's specific experiences (Foschiera et al., 2024). Similarly, trauma-focused emotion-oriented interventions have shown beneficial effects on quality of life and self-compassion among women with sexual trauma experiences, indicating that direct work with trauma-related emotions may constitute an important pathway to recovery (Shirinkam & Rostamnejad, 2026).

One of the central psychological mechanisms through which trauma may continue to affect functioning is disruption of emotion regulation. Emotion regulation refers broadly to the processes through which individuals identify, understand, modulate, express, and respond to emotional states in ways that are compatible with situational demands and personal goals. Trauma may interfere with these processes by increasing sensitivity to emotional cues while simultaneously encouraging avoidance or suppression of emotions perceived as dangerous, unacceptable, or uncontrollable. For women heads of household, such patterns may be reinforced by social expectations that they remain strong, self-sufficient, and emotionally stable for their children. Consequently, sadness, fear, anger, loneliness, and vulnerability may be inhibited even when these emotions signal legitimate unmet needs. Empirical findings indicate that emotion-regulation training can

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improve important psychosocial outcomes among women heads of household, including social intelligence and quality of life, suggesting that emotion regulation represents a clinically relevant intervention target in this population (Ardani & Eslami, 2024; Bakhshandeh Amnieh, 2018).

Emotional inhibition is particularly important in understanding the adjustment difficulties of trauma-exposed individuals. Emotional inhibition involves the restriction, concealment, or suppression of emotional experience and expression, often because emotions are perceived as unacceptable, threatening, shameful, or likely to generate interpersonal consequences. Although temporary inhibition can sometimes serve adaptive social functions, chronic emotional inhibition may interfere with emotional processing and prevent individuals from recognizing needs, communicating distress, obtaining social support, and integrating painful experiences. Psychometric research conducted in Iran has supported the assessment of emotional inhibition as a meaningful psychological construct, including within clinical populations (Asadollahi et al., 2022). More importantly, research has demonstrated that emotional inhibition can mediate the relationship between emotional awareness, stressful life events, and posttraumatic stress symptoms, suggesting that inhibition is not merely an accompanying symptom but may represent an important mechanism through which difficult experiences become associated with persistent psychological distress (Asadollahi et al., 2024). Therapeutic approaches designed for emotionally inhibited and fearful patients similarly emphasize that avoidance of emotion can preserve maladaptive beliefs and prevent corrective emotional experiences (Fassbinder & Arntz, 2019).

Emotion-Focused Therapy provides a particularly relevant theoretical and therapeutic framework for addressing these difficulties. EFT conceptualizes emotion as a fundamental system of human meaning, motivation, and adaptation rather than simply as a symptom to be controlled. From this perspective, psychological distress frequently develops when primary adaptive emotions are inaccessible, avoided, interrupted, or replaced by secondary maladaptive emotional reactions. Treatment therefore aims to increase emotional awareness, facilitate acceptance and symbolization of emotional experience, identify underlying needs, transform maladaptive emotional responses, and enable more adaptive action tendencies (Greenberg, 2017). Rather than encouraging clients to suppress painful emotions, EFT provides structured methods through which they can safely approach, differentiate, express, regulate, and transform those emotions. This orientation may be particularly appropriate for trauma-exposed women heads of household whose emotional difficulties often involve simultaneous experiences of fear, grief, shame, anger, guilt, and responsibility.

Contemporary developments in EFT have further emphasized its applicability to complex trauma. Trauma-related difficulties frequently involve unresolved relational injuries, chronic shame, self-blame, attachment insecurity, emotional avoidance, and fragmented autobiographical meanings. Emotion-focused work with complex trauma therefore seeks not merely to reduce distress but to access underlying adaptive emotions and needs that can reorganize traumatic emotional structures. Specific experiential procedures, including two-chair dialogues for self-critical conflicts and empty-chair work for unresolved interpersonal injuries, can help individuals move from immobilizing shame, fear, or helplessness toward adaptive grief, assertive anger, self-protection, self-compassion, and agency (Paivio & Pascual-Leone, 2023). A recent integrative review of EFT and trauma similarly concluded that emotion-focused interventions provide a coherent framework for understanding how traumatic emotional memories can be accessed and transformed through corrective emotional processing (Kadiroğlu et al., 2026). These mechanisms are highly relevant to women whose traumatic histories coexist with ongoing demands for caregiving and social functioning.

Evidence from different populations also supports the broader effectiveness of EFT. Emotion-focused group therapy has been associated with improvements in social intimacy, social acceptance, and self-compassion among individuals seeking psychological services for anxiety-related difficulties (Naderian et al., 2022). EFT has also demonstrated beneficial effects in emotionally demanding relational contexts, including improvements in adjustment and psychological health among couples experiencing infertility (Najafi, 2016). Research comparing emotion-focused approaches with other therapeutic models has further suggested that EFT can improve difficulties associated with limited emotional identification and expression, including alexithymic tendencies (Izadi, 2023). Taken together, these findings support the use of emotion-focused interventions for psychological problems characterized by emotional avoidance, inhibited expression, relational distress, and difficulty processing painful experiences.

Nevertheless, trauma recovery cannot be conceptualized solely as the reduction of negative symptoms. An exclusive

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emphasis on emotional pain, dysregulation, and psychopathology may underestimate the possibility that individuals can develop new strengths, meanings, relationships, and perspectives through the process of coping with adversity. Positive psychology provides a complementary framework by directing attention toward psychological resources that contribute to optimal functioning, including hope, gratitude, meaning, resilience, positive relationships, character strengths, optimism, and engagement with life. Positive-psychology interventions seek to identify and cultivate these capacities rather than assuming that well-being will automatically emerge after symptom reduction. This perspective may be especially important for women heads of household, whose daily survival frequently requires substantial perseverance, courage, responsibility, creativity, self-control, and care for others, even when they do not consciously recognize these characteristics as personal strengths.

Character strengths represent one of the central constructs within positive psychology. They refer to positively valued individual capacities that can be recognized, intentionally applied, and developed in daily life. For trauma-exposed women, identifying strengths may counteract self-concepts dominated by helplessness, inadequacy, failure, or victimization. The availability of psychometrically supported measures of character strengths in Iranian populations also facilitates systematic assessment of this construct in intervention research (Sharifi Ardani et al., 2025). Strength-based interventions may allow women to reinterpret characteristics developed through adversity, such as persistence, bravery, kindness, perspective, and hope, as psychological resources rather than merely as obligations imposed by difficult circumstances. This shift can contribute to a more agentic identity in which the individual is recognized not only as someone who has endured trauma but also as someone capable of active adaptation.

Positive psychology is also closely connected with the concept of posttraumatic growth. Posttraumatic growth refers to positive psychological changes that may arise through the effort to cope with highly challenging circumstances. These changes can include greater appreciation of life, deeper interpersonal relationships, recognition of new possibilities, increased personal strength, and transformations in existential or spiritual meaning. Importantly, posttraumatic growth does not imply that trauma is desirable or that distress disappears; rather, it suggests that constructive psychological developments can coexist with pain and emerge through active meaning-making. Research has shown that positive-psychology interventions can increase posttraumatic growth and reduce psychological distress among individuals who have experienced major adverse events, indicating that intentionally strengthening positive psychological processes may facilitate adaptation after trauma (Malekpour Golsafidi et al., 2022). Positive-psychology interventions have likewise demonstrated effectiveness in improving psychological well-being in nonclinical and vulnerable populations, supporting their broader applicability for enhancing adaptive functioning (Yaghoubi Abolghasem, 2019).

Hope is another particularly relevant positive-psychology construct for women heads of household. Such women may face chronic concerns regarding financial security, parenting responsibilities, housing, employment, social isolation, and future independence. Trauma can intensify these concerns by narrowing future expectations and creating a sense that adverse outcomes are unavoidable. Hope-oriented interventions can challenge this constriction by helping individuals identify meaningful goals, develop multiple pathways toward those goals, and strengthen a sense of personal agency. Similarly, gratitude, savoring, benefit finding, and meaning-making may help individuals regain sensitivity to positive aspects of experience without invalidating their suffering. This balance is especially important in trauma-informed work, because premature positivity can minimize emotional pain, whereas exclusive immersion in traumatic material can reinforce an identity organized around suffering.

The theoretical rationale for integrating EFT and positive psychology therefore lies in their complementary therapeutic functions. EFT provides methods for accessing and transforming unresolved emotional pain, while positive psychology provides methods for consolidating strengths, hope, meaning, and future orientation. Trauma-exposed individuals often require both processes. Before positive resources can be fully mobilized, painful emotions may need to be acknowledged, differentiated, expressed, and transformed. Conversely, emotional processing alone may not sufficiently address the need to reconstruct identity, strengthen character resources, generate future goals, and derive meaning from survival. An integrative intervention can therefore move progressively from emotional awareness and safety, through deeper emotional processing and repair, toward strength identification, hope, meaning-making, positive relationships, and posttraumatic growth.

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Attachment theory offers an additional conceptual basis for this integration. Experiences of safety, responsiveness, trust, and emotional availability in significant relationships shape expectations concerning both the self and others. When important relationships are characterized by loss, rejection, inconsistency, violence, or neglect, individuals may develop expectations that emotional needs will not be met or that vulnerability will lead to further injury. Such patterns can affect later emotion regulation, interpersonal trust, and help-seeking. Bowlby's attachment framework emphasizes the importance of secure relational experiences for emotional development and adaptive functioning (McLeod, 2024). A supportive therapeutic group can therefore provide a context in which difficult emotions are acknowledged without judgment, interpersonal responses can be reconsidered, and new experiences of validation and connection can emerge. Integrating this relational safety with strength-based work may be particularly important for trauma-exposed women who have learned to equate dependence or emotional expression with weakness.

Existing research has provided useful evidence regarding psychological empowerment, emotion regulation, EFT, positive psychology, and trauma-focused interventions, yet these lines of research have often developed separately. Studies involving women heads of household have largely examined isolated interventions aimed at emotion regulation, social empowerment, psychological well-being, or quality of life (Ardani & Eslami, 2024; Bakhshandeh Amnieh, 2018; Rezaeian et al., 2018; Torabi Momen et al., 2017). Trauma-focused studies, meanwhile, have demonstrated the value of psychotherapy and emotion-focused techniques for women exposed to interpersonal or sexual trauma (Foschiera et al., 2024; Shirinkam & Rostamnejad, 2026), while EFT research has highlighted emotional transformation, self-compassion, interpersonal functioning, and adaptive adjustment (Greenberg, 2017; Naderian et al., 2022; Najafi, 2016; Paivio & Pascual-Leone, 2023). Positive-psychology research has separately emphasized well-being, character strengths, and posttraumatic growth (Malekpour Golsafidi et al., 2022; Sharifi Ardani et al., 2025; Yaghoubi Abolghasem, 2019). This fragmentation leaves an important gap concerning whether an intervention deliberately integrating emotional processing with positive psychological development can produce broader benefits than either approach alone.

A second gap concerns intervention development itself. Psychological interventions are often transferred to target populations without sufficiently incorporating the lived experiences of those who will receive them. For trauma-exposed women heads of household, intervention relevance may depend on recognizing culturally and socially specific experiences such as the expectation to appear strong for children, shame associated with help-seeking, financial and caregiving burdens, fear of judgment, unresolved grief or anger toward significant others, and the tendency to overlook one's own strengths while fulfilling multiple responsibilities. Developing an intervention through qualitative exploration of these experiences can increase contextual appropriateness, while expert content validation can establish whether the resulting therapeutic components are relevant, clear, necessary, and feasible. Such a developmental process is particularly important when combining established therapeutic approaches into a new structured package.

The current study therefore conceptualized psychological adaptation among trauma-exposed women heads of household as involving both the modification of maladaptive emotional processes and the strengthening of positive psychological resources. Emotional self-regulation and emotional inhibition were selected as proximal indicators of changes in emotional functioning, while character strengths and posttraumatic growth represented strength-based and growth-oriented outcomes. This multidimensional framework made it possible to determine not only whether the intervention reduced emotional difficulties, but also whether it enhanced positive capacities that could support longer-term adaptation. Furthermore, by comparing EFT alone, positive psychology alone, the integrative intervention, and a control condition across pretest, posttest, and follow-up assessments, the design allowed the relative contribution of each therapeutic orientation to be examined rather than merely establishing whether the newly developed package was superior to no intervention.

Accordingly, the aim of the present study was to develop and validate an integrative counseling package based on Emotion-Focused Therapy and positive psychology and to evaluate its effectiveness, compared with EFT alone, positive psychology alone, and a control condition, in improving emotional self-regulation, reducing emotional inhibition, enhancing character strengths, and promoting posttraumatic growth among trauma-exposed women heads of household.

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2. Methods and Materials

2.1. Study design and Participant

The present study was developmental-applied in terms of purpose and employed a sequential exploratory mixed-methods design consisting of a qualitative developmental phase followed by a quantitative effectiveness-evaluation phase. The developmental orientation of the study was related to the formulation and validation of a new integrative counseling package combining the principles and techniques of Emotion-Focused Therapy (EFT) and positive psychology for trauma-exposed women heads of household. In the first, qualitative phase, the intervention package was developed through a systematic review and content analysis of specialized theoretical and empirical literature, semi-structured interviews with trauma-exposed women heads of household, and expert evaluation of the preliminary intervention package. The interview data were analyzed thematically and integrated with the theoretical components derived from EFT and positive psychology to formulate the initial intervention framework. The preliminary package was subsequently submitted to a panel of 10 experts, including five clinical psychologists holding doctoral degrees with at least five years of professional experience working with trauma-exposed women, three family counselors, and two psychiatrists. The experts evaluated the relevance, clarity, simplicity, and necessity of the proposed session objectives and techniques. Content validity was quantified using the Content Validity Index (CVI) and Content Validity Ratio (CVR). The mean CVI of the integrative package was 0.86, with item-level values ranging from 0.79 to 0.95, while the mean CVR was 0.78, with values ranging from 0.65 to 0.90. All components therefore exceeded the predetermined acceptability thresholds. Based on the experts' recommendations, minor revisions were made, including modification of the duration of selected exercises, incorporation of more concrete examples, and reorganization of several techniques in the eighth session, after which the final 10-session integrative counseling package was prepared for implementation.

The population of the qualitative phase consisted of trauma-exposed women heads of household receiving services from the Women's Empowerment Headquarters of Tehran Municipality, District 2. Participants were recruited purposively with an emphasis on obtaining information-rich cases and maximizing variation in age, reason for becoming head of household, duration of household headship, and severity of trauma experiences. Fourteen women were ultimately interviewed. Participants were approximately 30 to 50 years old, had become heads of household as a consequence of either spousal death or divorce, had been responsible for their households for approximately 2 to 10 years, and had moderate-to-severe trauma histories, reflected in Childhood Trauma Questionnaire scores ranging approximately from 60 to 90. Semi-structured interviews continued until data saturation was achieved, with no substantively new concepts emerging after approximately the twelfth interview; two additional interviews were conducted to verify saturation. In addition to satisfying the general eligibility criteria of the study, qualitative-phase participants were required to have sufficiently rich experience of both trauma and household headship and to be willing to discuss their experiences in depth.

The quantitative phase used a four-group quasi-experimental pretest-posttest-follow-up design with a three-month follow-up. The study compared three active intervention conditions, namely EFT alone, positive psychology alone, and the newly developed integrative EFT-positive psychology counseling package, with a wait-list control condition. The statistical population comprised all trauma-exposed women heads of household who had an active record at the Women's Empowerment Headquarters of Tehran Municipality, District 2, during the second six months of 2025-2026 and who were receiving supportive, counseling, or entrepreneurship services from the center. According to administrative records, approximately 250 women heads of household were registered at the center during the study period, of whom approximately 120 reported a history of trauma during preliminary screening. Initially, 72 eligible women were selected from the screened population and randomly allocated to four groups of 18 participants each. Because attrition was anticipated due to the longitudinal nature of the study and the vulnerability of the target population, the recruited sample exceeded the minimum planned analytic sample of 60 participants by approximately 20%. Twelve participants were lost during the intervention and follow-up process because of excessive absence, relocation, illness, or other circumstances preventing continued participation. Consequently, data from 60 participants, with 15 women in each of the four study groups, were included in the final analyses.

Eligibility for the quantitative phase required being female and between 25 and 55 years of age; being the head of a household because of confirmed divorce or the death of a spouse, with at least two years having elapsed since the event; having at least one dependent child younger than 18

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years; obtaining a Childhood Trauma Questionnaire score of 60 or higher; having received no systematic psychological intervention, including individual or group psychotherapy, during the preceding six months; possessing sufficient literacy to complete the questionnaires independently; and providing informed consent to participate in the 10-session group intervention and complete the assessments at pretest, posttest, and three-month follow-up. Exclusion criteria included absence from more than two intervention sessions without prior coordination, the presence of an acute psychotic disorder or an acute episode of bipolar I disorder based on center records or clinical interview, active substance or alcohol use according to self-report or social-worker reports, or occurrence of a severe crisis during the study, such as the death of a child or a major accident, that made continued participation clinically inappropriate.

For the quantitative phase, the initial pool of potentially eligible participants underwent screening using the Childhood Trauma Questionnaire and an eligibility interview. Seventy-two women were then selected using simple random sampling by assigning an identification number to each eligible individual and selecting numbers through a random-number procedure. Participants were subsequently randomly allocated by lottery to the EFT-only, positive-psychology-only, integrative, and control groups. Participants were not informed of the exact intervention condition to which they had been allocated until completion of the pretest assessment. Follow-up assessments were administered by an evaluator who had not participated in intervention delivery and was unaware of group allocation. At baseline, all participants completed the outcome measures before initiation of the intervention. Each active treatment was delivered twice weekly for five consecutive weeks, resulting in 10 sessions of 90 minutes. The posttest assessment was administered approximately 48 hours after completion of the tenth session, and the follow-up assessment was conducted three months after intervention completion. The control group received no structured psychological intervention during the active study period other than the center's routine supportive service, consisting of approximately one 30-minute supportive counseling session per month with a social worker. Following completion of the three-month follow-up assessment, members of the control group were offered the 10-session integrative counseling program.

All intervention sessions were conducted by the researcher, while a trained research assistant with a master's degree in counseling coordinated attendance, collected homework assignments, and assisted with administrative procedures. To minimize contamination between the intervention conditions, the groups attended sessions on different days and, where necessary, in separate rooms with adequate temporal separation between programs. Participants were also asked not to share intervention materials or detailed session content with members of other study groups during the research period. Ethical principles were observed throughout both phases of the study. Written informed consent was obtained before participation, data were stored under participant codes rather than names, and participants were informed that withdrawal from the study would have no adverse consequences for the services they received from the center. Because several intervention activities involved exploration of painful autobiographical experiences and intense emotions, participants were also provided with information regarding available crisis-support services. The wait-list control group received the integrative intervention after completion of all study assessments as an ethical provision.

2.2. Measures

The Childhood Trauma Questionnaire (CTQ) was used as the principal screening instrument for identifying participants with a meaningful history of childhood trauma. The CTQ was developed by Bernstein et al. (2003) and contains 28 items, of which 25 assess five major dimensions of childhood maltreatment: emotional neglect, physical neglect, emotional abuse, physical abuse, and sexual abuse. The remaining three items constitute a minimization-denial validity scale. Items are rated on a five-point Likert scale ranging from 1, indicating “never,” to 5, indicating “very often.” Scores on the principal items can range from 25 to 125, with higher scores reflecting greater exposure to childhood trauma. In the present study, a score of 60 or higher was used as the eligibility threshold for trauma exposure. Previous Iranian psychometric investigations have reported satisfactory internal consistency for the total scale and its subscales, with coefficients generally exceeding acceptable psychometric standards. In the pilot assessment conducted for the present study, Cronbach's alpha for the total CTQ was 0.89. The instrument was administered during screening rather than repeatedly as an intervention outcome measure, and the baseline CTQ score was also considered as a potential control variable in supplementary statistical analyses.

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The Emotion Regulation Questionnaire (ERQ) was used to assess emotion-regulation processes, with particular emphasis in the present study on adaptive cognitive reappraisal as an indicator of emotional self-regulation. The version employed consisted of 20 items covering cognitive reappraisal and expressive suppression. Cognitive reappraisal represents the tendency to reinterpret emotionally evocative situations in ways that modify their emotional impact, whereas expressive suppression reflects attempts to inhibit the outward expression of emotional responses. Items were rated on a five-point Likert scale ranging from 1, “strongly disagree,” to 5, “strongly agree,” producing a total score ranging from 20 to 100. Because adaptive emotional self-regulation was a central outcome of the intervention, the cognitive reappraisal score was used as the primary ERQ indicator in the analyses, with higher cognitive reappraisal scores interpreted as reflecting more adaptive emotion regulation. Iranian studies have demonstrated satisfactory reliability and convergent validity for the instrument, including associations with measures of difficulties in emotion regulation. In the pilot study conducted before the main investigation, Cronbach's alpha for the cognitive reappraisal component was 0.85.

The Emotional Inhibition Scale (EIS) was administered to assess participants' tendency to inhibit or suppress the expression of emotional experiences. The instrument, associated with the work of Roger and Najarian (1989), consists of 16 items examining inhibition in the expression of emotions such as anger, sadness, fear, and happiness. Participants indicate how frequently each statement describes their typical emotional behavior using a five-point Likert response format ranging from 1, “never,” to 5, “always.” After reverse scoring the positively worded items where necessary, scores range from 16 to 80, with higher scores indicating greater emotional inhibition. Previous Iranian psychometric evaluations have demonstrated satisfactory internal consistency, test-retest reliability, and convergent validity with conceptually related constructs such as alexithymia. In the preliminary assessment of the present sample, Cronbach's alpha for the EIS was 0.84. The scale was administered at pretest, posttest, and three-month follow-up to evaluate whether the interventions reduced maladaptive inhibition of emotional experience and expression.

The Values in Action Inventory of Strengths-Short Form (VIA-IS) was employed to assess participants' perceived character strengths. The VIA classification developed by Peterson and Seligman (2004) conceptualizes 24 character strengths organized under six broad virtues. Whereas the original VIA-IS contains 240 items, the short form used in the present study included 24 items, with each item representing one character strength. Responses were provided on a five-point Likert scale ranging from 1, “very much unlike me,” to 5, “very much like me.” Total scores can range from 24 to 120, with higher scores indicating stronger recognition and utilization of one's character strengths. The instrument was especially relevant to the positive-psychology and integrative intervention conditions because identification, application, and development of personal strengths constituted central therapeutic components. Iranian psychometric research on the short form has supported its internal consistency and construct-related validity. In the pilot phase of the present study, Cronbach's alpha for the total VIA-IS score was 0.86. The questionnaire was administered at all three quantitative assessment occasions.

The Posttraumatic Growth Inventory (PTGI) was used to assess positive psychological changes associated with struggling with traumatic and highly challenging life experiences. Developed by Tedeschi and Calhoun (1996), the inventory contains 21 items distributed across five domains: appreciation of life, relating to others, new possibilities, personal strength, and spiritual or existential change. Items are scored on a six-point scale ranging from 0, indicating no perceived change, to 5, indicating a very great degree of change. The total score ranges from 0 to 105, with higher scores indicating greater posttraumatic growth. The PTGI was particularly relevant to the conceptual framework of the integrative intervention because the package was designed not only to reduce maladaptive emotional processes but also to facilitate constructive meaning-making, recognition of strengths, improved relationships, and the development of new life goals following trauma. Previous Iranian studies have demonstrated strong internal consistency, satisfactory test-retest reliability, and support for the construct validity of the instrument. In the pilot assessment conducted in the present study, Cronbach's alpha for the total PTGI was 0.89. The instrument was administered at pretest, posttest, and three-month follow-up.

A semi-structured interview guide was used during the qualitative phase to identify the emotional, cognitive, interpersonal, meaning-related, and strength-based needs of trauma-exposed women heads of household and to inform development of the integrative counseling package. The interviews explored participants' experiences of trauma,

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emotional reactions to stressful and traumatic events, patterns of emotional suppression and expression, difficulties in emotion regulation, perceptions of personal strengths, coping resources, experiences of loss and adversity, interpersonal relationships, perceived changes following trauma, sources of hope and meaning, and expectations regarding psychological counseling. Interviews were conducted individually in a confidential setting and continued until thematic saturation was achieved. The interviewer used open-ended questions and follow-up probes to clarify experiences and obtain sufficiently detailed descriptions without imposing predetermined interpretations on participants' narratives. The interviews were transcribed and subsequently subjected to thematic analysis.

An expert content-validity evaluation form was used to assess the initial version of the integrative intervention package. Ten specialists evaluated individual objectives, techniques, activities, and session components in terms of relevance, clarity, simplicity, and necessity. Relevance, clarity, and simplicity were scored on four-point scales and were used to calculate item-level and scale-level CVI values based on the Waltz and Bausell approach. Necessity was evaluated using the three-category Lawshe procedure, in which experts classified each intervention component as essential, useful but not essential, or unnecessary. CVR values were subsequently calculated for each component. For the panel of 10 experts, a CVR of 0.62 or higher was considered acceptable, while a CVI of approximately 0.80 or above was considered evidence of satisfactory content validity. The resulting indices supported retention of the package components, with only minor revisions required before implementation.

2.3. Intervention

Three active group interventions were implemented: EFT alone, positive psychology alone, and the newly developed integrative EFT-positive psychology counseling package. Each intervention consisted of 10 group sessions lasting approximately 90 minutes, delivered twice weekly over five weeks. The EFT protocol was developed primarily around the principles of emotional awareness, emotional schemes, primary and secondary emotion differentiation, emotional expression, regulation, transformation, two-chair work, empty-chair work, interpersonal conflict resolution, and reconstruction of traumatic narratives. Early EFT sessions introduced basic emotions and emotional schemes and helped participants identify bodily sensations, meanings, needs, and action tendencies associated with emotionally significant situations. Middle sessions employed two-chair dialogues to address internal self-critical conflicts, empty-chair work for unresolved relationships, training in emotionally congruent expression through “I” statements, and structured emotion-regulation and emotion-transformation exercises. Later sessions focused on revised interpersonal patterns, narrative reconstruction of traumatic experiences, reinterpretation of previously distressing experiences, consolidation of emotional changes, and development of a maintenance plan. The positive-psychology protocol was based on major principles of positive psychology, including the PERMA framework, identification and use of character strengths, learned optimism, self-acceptance rather than maladaptive perfectionism, benefit finding, forgiveness, gratitude, savoring, hope and goal-setting, positive relationships, altruism, meaning, and self-transcendence. Participants completed experiential activities such as identifying signature strengths, writing gratitude and self-reflective letters, practicing “three good things,” applying savoring techniques, constructing pathways toward personally meaningful goals, strengthening supportive relationships, and engaging in prosocial actions. The integrative intervention constituted the principal package developed in the study and followed a three-stage therapeutic sequence. Sessions one through three focused on emotional preparation and awareness by combining emotional-scheme identification with PERMA, character-strength recognition, self-concept exploration, processing of regret and unfinished experiences, and learned optimism. Sessions four through seven emphasized deeper emotional processing and repair through two-chair and empty-chair techniques, self-compassion, benefit finding, forgiveness, identification and reduction of emotional inhibition, adaptive emotional expression, emotion regulation and transformation, acceptance of “good enough” performance, gratitude, and constructive reinterpretation of difficult experiences. Sessions eight through ten emphasized future construction and psychological growth through improved interpersonal interaction, hope-based goal setting, the “open and closed doors” exercise, posttraumatic growth, reconstruction of personal narratives from a survivor or growth-oriented perspective, savoring, strengthening positive relationships, altruism, meaning-making, self-transcendence, and consolidation of therapeutic gains. Participants received between-session assignments to facilitate the transfer of skills to daily life. The control group did not participate in

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any structured psychological intervention during the study but continued to receive routine services provided by the center. Following completion of the three-month follow-up, the control participants were offered the full integrative counseling package.

2.4. Data Analysis

Qualitative and quantitative data were analyzed separately in accordance with the sequential exploratory mixed-methods design and were subsequently integrated during development and evaluation of the counseling package. Qualitative interview data from the 14 women heads of household were analyzed according to Braun and Clarke's thematic analysis framework using MAXQDA 2020. Analysis involved repeated reading of the verbatim transcripts to achieve familiarity with the data, generation of initial descriptive and interpretive codes, comparison and grouping of related codes into candidate subthemes, organization of subthemes into broader themes, review of the internal coherence and external distinctiveness of the themes, definition and naming of the final themes, and preparation of an interpretive account supported by representative participant statements. Findings from the thematic analysis were then integrated with theoretical and intervention components identified in the specialized literature to construct the preliminary EFT-positive psychology package. Quantification of expert judgments was performed by calculating item-level and overall CVI and CVR values. A CVI of approximately 0.80 or higher and a CVR exceeding the critical value of 0.62 for a 10-member expert panel were regarded as evidence supporting retention of intervention components.

Quantitative analyses were performed using IBM SPSS Statistics version 27. Descriptive statistics, including means, standard deviations, minimum scores, and maximum scores, were calculated for the dependent variables across the EFT, positive-psychology, integrative, and control groups at pretest, posttest, and three-month follow-up. Before testing the study hypotheses, the assumptions required for parametric repeated-measures analyses were examined. Normality of the score distributions was assessed using the Shapiro-Wilk test within each group and outcome variable, homogeneity of variances was examined using Levene's test, and homogeneity of covariance matrices was evaluated using Box's M test, for which a conservative significance criterion of $p > .001$ was used. Mauchly's test was employed to examine the sphericity assumption for within-subject effects; when sphericity was violated, the Greenhouse-Geisser correction was applied.

The principal intervention effects were evaluated using repeated-measures multivariate analysis of variance, with group as the between-subjects factor at four levels—EFT, positive psychology, integrative intervention, and control—and time as the within-subjects factor at three levels—pretest, posttest, and three-month follow-up. Particular attention was given to the group-by-time interaction because a statistically significant interaction indicated differential change in the outcome variables across the four conditions. When significant omnibus effects were identified, Bonferroni-adjusted pairwise comparisons were conducted to determine differences between measurement occasions within each group and differences among groups at the relevant assessment points. Where specific posttest comparisons required adjustment for baseline differences, univariate analysis of covariance was additionally employed using the corresponding pretest score as a covariate. Childhood trauma severity, as assessed by the CTQ, was also considered as a control variable where appropriate. Effect sizes were reported using partial eta squared for omnibus repeated-measures and covariance analyses, with values of approximately .01, .06, and .14 interpreted as small, medium, and large effects, respectively. Cohen's d was used where appropriate for pairwise effect-size estimation, with values of approximately 0.20, 0.50, and 0.80 interpreted as small, medium, and large effects. The statistical significance level was set at .05 for all analyses except where a more conservative threshold or Bonferroni adjustment was required.

3. Findings and Results

The findings were organized according to the two sequential phases of the study. The first phase focused on developing and validating the integrative counseling package through qualitative interviews with trauma-exposed women heads of household and subsequent expert content validation. Fourteen women participated in the qualitative phase. Their mean age was 38.40 years (SD = 7.80), and the mean duration of household headship was 4.60 years (SD = 3.20). Eight participants had become heads of household following the death of their spouses, whereas six had assumed this role following divorce. Their mean Childhood Trauma Questionnaire score was 68.30 (SD = 8.60), with scores ranging from 60 to 85. Each semi-structured

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interview lasted approximately 60 to 90 minutes. Following verbatim transcription and thematic analysis of the interviews, five principal themes and their associated subthemes were identified, as presented in Table 1.

Table 1

Main Themes and Subthemes Extracted from Interviews with Trauma-Exposed Women Heads of Household

Main theme	Subthemes	Representative quotation
Inhibition–shame cycle	Fear of social judgment ("What will others say?"); concern about appearing weak in front of children; suppression of anger to maintain appearances; shame associated with asking for help	"I can never cry because my child is watching me. I have to be strong. But at night, when I am alone, I feel like screaming." (Participant 7, age 42, widowed)
Need for safe emotional expression	Absence of an empathic listener; fear of emotional outbursts if feelings are expressed; desire to scream when alone; need for another person to acknowledge one's pain and suffering	"I wish I could scream just once and say how tired I am. But there is no one to listen. If I cry in front of my mother, she says I have to stay strong for my children." (Participant 3, age 35, divorced)
Hidden and unrecognized character strengths	Recognition of perseverance and patience during crises; pride in the ability to manage multiple roles simultaneously; insufficient awareness of personal strengths; need for others to recognize one's strengths	"I always thought I was weak, but everyone says I am very patient. I had never really thought that this patience itself could be a major strength." (Participant 11, age 48, widowed)
Meaning derived from responsibility for children	Children as motivation to continue living; concern about children being adversely affected by the mother's circumstances; guilt over inability to meet children's needs; hope for children's future as a source of meaning in suffering	"If it were not for my children, I would give up on everything. They are the only reason I wake up every day and keep fighting. I want to see them become doctors someday." (Participant 2, age 31, divorced)
Fear of the future and need for hope	Economic and occupational concerns; fear of loneliness in later life; need for successful female role models; desire for independence and self-reliance	"My biggest fear is that I will not be able to raise my children properly. I want to reach a day when I can tell myself, 'Well done, you made it.' But right now, when I look ahead, there is still a long way to go." (Participant 8, age 39, widowed)

As shown in Table 1, the qualitative analysis revealed five interrelated experiential domains that informed development of the intervention package. The inhibition–shame cycle indicated that participants frequently suppressed anger, sadness, and vulnerability because of perceived social expectations and their perceived obligation to appear strong in front of their children. Closely related to this theme was the need for safe emotional expression, reflecting the absence of nonjudgmental interpersonal environments in which participants could acknowledge and communicate distress. These two themes provided direct support for incorporating EFT techniques addressing emotional awareness, inhibition, expression, and unmet emotional needs. The third theme revealed that participants possessed substantial strengths, such as perseverance, patience, courage, and capacity for managing multiple responsibilities, but often failed to identify these qualities as personal resources. This finding supported the incorporation of character-strength identification and positive-psychology exercises. Responsibility for children emerged as a major source of existential meaning, whereas uncertainty regarding economic security, parenting, aging, and independence generated a strong need for hope and future orientation. Consequently, the final integrative package incorporated two-chair work to address internal self-critical conflicts, empty-chair techniques to facilitate safe emotional expression toward significant others, character-strength and learned-optimism exercises to increase recognition of personal resources, and benefit-finding, meaning-making, hope, and goal-setting strategies to support future-oriented psychological adaptation.

After development of the preliminary 10-session integrative package from the theoretical literature and qualitative findings, its content validity was evaluated by a panel of 10 specialists consisting of five doctoral-level clinical psychologists, three family counselors, and two psychiatrists. Each session and its therapeutic components were evaluated for relevance, clarity, and simplicity for calculation of the Content Validity Index (CVI), as well as necessity for calculation of the Content Validity Ratio (CVR). The resulting session-level indices are presented in Table 2.

Table 2

Content Validity Index and Content Validity Ratio for Sessions of the Integrative Counseling Package

Session	Session focus	CVI	CVR

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1	Introduction, basic emotions, and PERMA	0.93	0.85
2	Self-concept and character strengths in painful experiences	0.88	0.80
3	Last-day-of-life letter, strength analysis, and optimism	0.85	0.75
4	Two-chair technique and drawing the vulnerable self	0.87	0.82
5	Empty-chair technique, benefit finding, and forgiveness	0.89	0.85
6	Emotional inhibition, emotional expression, and satisfaction versus perfectionism	0.79; 0.84 after revision	0.70
7	Emotion regulation, emotion transformation, and gratitude	0.86	0.78
8	New interactions, hope, and the open- and closed-doors technique	0.84	0.75
9	Posttraumatic growth, narrative therapy, and savoring	0.88	0.80
10	Problem reformulation, positive relationships, altruism, and meaning	0.95	0.90

The results presented in Table 2 demonstrated satisfactory-to-excellent content validity for the developed package. The mean CVI for the complete intervention was 0.86 (SD = 0.05), exceeding the predetermined acceptability criterion of 0.80. Initial session-level CVI values ranged from 0.79 to 0.95. Session 6 initially obtained the lowest CVI value (0.79); after specialists recommended adding more concrete examples relevant to the daily experiences of women heads of household, its CVI increased to 0.84. The highest CVI values were obtained for Session 1 (0.93) and Session 10 (0.95). The mean CVR for the package was 0.78 (SD = 0.06), exceeding the critical value of 0.62 adopted for the 10-member expert panel. Session-level CVR coefficients ranged from 0.70 to 0.90, indicating that all sessions met the criterion for content necessity. Session 10 obtained the highest CVR (0.90), followed by Sessions 1 and 5 (both 0.85), while Session 6 obtained the lowest value (0.70). Expert feedback resulted in minor modifications, including the provision of more concrete examples in Session 6, additional time for emotional-expression exercises, clearer differentiation between short- and long-term goals in Session 8, and greater attention to individual differences in trauma severity. Following these revisions, the 10-session integrative package was approved for implementation in the quantitative phase.

The second phase evaluated the effectiveness of the validated counseling package. Sixty participants who completed all required assessments were included in the final analysis, with 15 participants in each of the EFT, positive psychology, integrative, and control groups. The primary outcomes were emotional self-regulation, emotional inhibition, character strengths, and posttraumatic growth. Descriptive statistics for all four outcome variables at pretest, posttest, and three-month follow-up are presented in Table 3.

Table 3

Means and Standard Deviations of the Outcome Variables Across the Three Measurement Occasions by Study Group

Variable	Time	EFT (n = 15), M (SD)	Positive Psychology (n = 15), M (SD)	Integrative (n = 15), M (SD)	Control (n = 15), M (SD)
Emotional self-regulation (ERQ)	Pretest	32.40 (4.80)	33.10 (5.20)	31.80 (4.90)	32.60 (5.00)
	Posttest	51.10 (5.60)	45.50 (5.80)	58.10 (6.10)	33.80 (5.30)
	Follow-up	48.30 (5.90)	44.20 (6.10)	56.40 (6.40)	34.10 (5.50)
Emotional inhibition (EIS)	Pretest	58.70 (6.20)	57.90 (5.90)	59.20 (6.50)	58.30 (6.00)
	Posttest	43.50 (5.40)	48.10 (5.70)	37.10 (4.80)	56.80 (6.30)
	Follow-up	45.80 (5.60)	49.30 (6.00)	39.40 (5.10)	57.20 (6.50)
Character strengths (VIA-IS)	Pretest	45.30 (6.00)	44.60 (5.80)	46.10 (6.30)	45.00 (5.90)
	Posttest	55.90 (5.90)	62.90 (6.40)	73.90 (7.10)	45.80 (6.20)
	Follow-up	53.70 (6.20)	60.80 (6.70)	71.50 (7.40)	46.30 (6.40)
Posttraumatic growth (PTG)	Pretest	24.20 (5.30)	23.80 (5.00)	25.10 (5.60)	24.50 (5.20)
	Posttest	37.40 (6.10)	45.30 (6.80)	56.70 (7.50)	25.60 (5.80)
	Follow-up	35.50 (6.40)	43.70 (7.20)	54.80 (7.80)	26.20 (6.10)

As shown in Table 3, baseline means were generally comparable across the four groups for all outcome variables. Following the interventions, emotional self-regulation increased in all three experimental groups, with the greatest

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improvement observed in the integrative group, whose mean increased from 31.80 at pretest to 58.10 at posttest and remained high at 56.40 at follow-up. Emotional inhibition showed the opposite pattern, with the greatest reduction again occurring in the integrative group, from 59.20 at baseline to 37.10 at posttest and 39.40 at follow-up. Character strengths increased most markedly among participants receiving the integrative intervention, rising from 46.10 at pretest to 73.90 at posttest and remaining at 71.50 at follow-up. A similarly pronounced pattern was found for posttraumatic growth, for which the integrative group's mean increased from 25.10 to 56.70 and remained at 54.80 three months later. The EFT group showed comparatively stronger changes in emotion-related outcomes, whereas the positive-psychology group demonstrated comparatively greater improvement in character strengths and posttraumatic growth. By contrast, the control group exhibited only minimal changes across the three measurement occasions. The maintenance of substantially improved scores at follow-up also indicated that the intervention effects, particularly those associated with the integrative package, were largely sustained over the three-month period.

To determine whether the observed posttest differences remained statistically significant after controlling for baseline scores, separate analyses of covariance were conducted for the four dependent variables. In each analysis, the corresponding pretest score was entered as the covariate and intervention group was entered as the fixed factor. The results are presented in Table 4.

Table 4

ANCOVA Results for Comparisons of the Four Groups at Posttest After Adjustment for Pretest Scores

Variable	Source	SS	df	MS	F	p	η^2
Emotional self-regulation (ERQ)	Group	2845.60	3	948.50	31.20	< .001	.64
	Error	1601.20	55	29.10			
Emotional inhibition (EIS)	Group	2510.30	3	836.80	29.70	< .001	.62
	Error	1548.90	55	28.20			
Character strengths (VIA-IS)	Group	4210.70	3	1403.60	42.80	< .001	.70
	Error	1802.50	55	32.80			
Posttraumatic growth (PTG)	Group	5120.40	3	1706.80	45.10	< .001	.71
	Error	2081.60	55	37.80			

As indicated in Table 4, statistically significant between-group differences were found at posttest for all four outcome variables after adjustment for their corresponding baseline scores. The effect of group was significant for emotional self-regulation, $F(3, 55) = 31.20$, $p < .001$, $\eta^2 = .64$; emotional inhibition, $F(3, 55) = 29.70$, $p < .001$, $\eta^2 = .62$; character strengths, $F(3, 55) = 42.80$, $p < .001$, $\eta^2 = .70$; and posttraumatic growth, $F(3, 55) = 45.10$, $p < .001$, $\eta^2 = .71$. All reported effect sizes substantially exceeded the conventional criterion for a large effect, indicating that group membership accounted for a considerable proportion of posttest variance after controlling for pretest scores. The largest effect was observed for posttraumatic growth, followed closely by character strengths, whereas the effects for emotional self-regulation and emotional inhibition were also large. These findings provide evidence that the observed improvements were not attributable merely to baseline differences and that the intervention conditions exerted differential effects on the psychological outcomes.

Because the omnibus group effects were statistically significant, Bonferroni-adjusted post hoc comparisons were conducted to determine which intervention groups differed from one another. Given the number of pairwise comparisons, the adjusted significance criterion was set at approximately .0083. The principal pairwise comparisons and corresponding Cohen's d effect sizes are presented in Table 5.

Table 5

Bonferroni Post Hoc Comparisons of Adjusted Posttest Means

Variable	Comparison	Mean difference	p	Cohen's d
Emotional self-regulation	Integrative > EFT	7.00	< .001	1.22
	Integrative > Positive Psychology	12.60	< .001	2.19
	Integrative > Control	24.30	< .001	4.23

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	EFT > Positive Psychology	5.60	< .001	0.98
Emotional inhibition	Integrative < EFT	−6.40	< .001	1.15
	Integrative < Positive Psychology	−11.00	< .001	1.98
	Integrative < Control	−19.70	< .001	3.55
	EFT < Positive Psychology	−4.60	.005	0.83
Character strengths	Integrative > EFT	18.00	< .001	2.77
	Integrative > Positive Psychology	11.00	< .001	1.69
	Integrative > Control	28.10	< .001	4.32
	Positive Psychology > EFT	7.00	< .001	1.08
Posttraumatic growth	Integrative > EFT	19.30	< .001	2.87
	Integrative > Positive Psychology	11.40	< .001	1.70
	Integrative > Control	31.10	< .001	4.63
	Positive Psychology > EFT	7.90	< .001	1.18

The pairwise comparisons presented in Table 5 demonstrated that the integrative intervention consistently produced the most favorable posttest outcomes. Emotional self-regulation was significantly higher in the integrative group than in the EFT, positive-psychology, and control groups, with large effect sizes ranging from d = 1.22 to d = 4.23. EFT also produced significantly greater emotional self-regulation than positive psychology, d = 0.98, suggesting that emotion-focused techniques exerted a particularly strong effect on this outcome. For emotional inhibition, lower scores represented a more favorable outcome. The integrative group showed significantly lower emotional inhibition than the EFT, positive-psychology, and control groups, with effect sizes ranging from d = 1.15 to d = 3.55. EFT also resulted in significantly less emotional inhibition than positive psychology, d = 0.83. A different relative pattern emerged for strength-related outcomes. Although the integrative intervention remained superior to all other conditions for character strengths, positive psychology produced significantly higher character-strength scores than EFT, with a large effect of d = 1.08. The same pattern was observed for posttraumatic growth: the integrative group outperformed EFT, positive psychology, and control, whereas positive psychology produced significantly greater posttraumatic growth than EFT, d = 1.18. The largest contrast in the entire set of comparisons was observed between the integrative and control groups for posttraumatic growth, d = 4.63. Overall, the findings indicated that EFT alone was particularly effective for emotion-regulation outcomes, positive psychology alone was comparatively more effective for strength-based and growth-oriented outcomes, and integration of the two approaches generated the strongest and most comprehensive effects across all four psychological outcomes.

4. Discussion

The present study aimed to develop and validate an integrative counseling package based on Emotion-Focused Therapy and positive psychology and to examine its effectiveness in improving emotional self-regulation, reducing emotional inhibition, strengthening character strengths, and promoting posttraumatic growth among trauma-exposed women heads of household. The findings supported the content validity of the developed package and demonstrated that all three active interventions were effective compared with the control condition, although the magnitude and pattern of improvement differed across treatment approaches. The integrative intervention consistently produced the strongest outcomes across all four dependent variables. EFT alone was comparatively more effective in improving emotional self-regulation and reducing emotional inhibition, whereas positive psychology alone produced stronger effects than EFT on character strengths and posttraumatic growth. These findings indicate that the combination of emotional processing and strength-based psychological development may provide a broader and more comprehensive therapeutic effect than either approach implemented independently.

The qualitative findings obtained during the developmental phase also provided an important empirical foundation for the structure of the intervention. Participants described a recurrent inhibition–shame cycle characterized by suppression of anger, sadness, fear, and vulnerability because of concerns about social judgment and the perceived need to appear strong in front of their children. They also reported a lack of safe opportunities for emotional expression, limited awareness of their own strengths, reliance on their children as a major source of meaning, and considerable anxiety regarding the future. These themes are consistent with the broader psychological literature on

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women heads of household, which shows that psychological vulnerability in this group cannot be reduced to economic difficulties alone but also involves emotional burden, role overload, social constraints, diminished well-being, and the need for psychological empowerment (Rezaeian et al., 2018; Torabi Momen et al., 2017; Zamani Moghadam & Afshani, 2021). The qualitative results therefore supported the decision to construct an intervention that simultaneously addressed emotional processing, self-perception, strengths, hope, meaning, and adaptive future orientation.

One of the principal quantitative findings was that the integrative intervention produced the greatest improvement in emotional self-regulation, followed by EFT, positive psychology, and the control condition. This pattern is theoretically consistent with the central assumptions of EFT. According to the emotion-focused perspective, adaptive psychological functioning depends not on suppressing or eliminating emotion but on increasing awareness of emotional experience, identifying the needs and meanings embedded within emotions, and transforming maladaptive emotional responses into more adaptive ones (Greenberg, 2017). The EFT component of the integrative package included emotional-scheme work, differentiation of primary and secondary emotions, two-chair dialogue, empty-chair work, training in emotional expression, and emotion-transformation procedures. These techniques may have enabled participants to recognize emotional cues earlier, interpret them more accurately, and respond to them with greater flexibility rather than relying on automatic suppression or avoidance.

The present finding is also aligned with previous research demonstrating the value of emotion-regulation interventions among women heads of household. Emotion-regulation training has been reported to improve social intelligence and quality of life in this population, suggesting that greater capacity to identify and manage emotional responses may generalize to broader interpersonal and psychological functioning (Ardani & Eslami, 2024; Bakhshandeh Amnieh, 2018). Similarly, emotion-focused group therapy has been found to improve social intimacy, social acceptance, and self-compassion, outcomes that depend substantially on adaptive emotional awareness and expression (Naderian et al., 2022). The relatively stronger performance of EFT compared with positive psychology on emotional self-regulation in the present study therefore appears conceptually coherent, because EFT directly targets the organization and transformation of emotional experience, whereas positive psychology approaches emotional functioning more indirectly through optimism, gratitude, strengths, meaning, and positive engagement.

The integrative intervention may have surpassed EFT alone because it did not end with emotional processing. Once participants were helped to recognize and regulate difficult emotional states, positive-psychology techniques provided additional resources for reinterpretation and future-oriented coping. Learned optimism, character-strength identification, hope-based goal setting, gratitude, savoring, and meaning-making may have increased participants' repertoire of adaptive responses after emotionally difficult experiences. In other words, the integrative package may have supported both the regulation of distress and the generation of alternative positive emotional and cognitive responses. This interpretation is compatible with contemporary trauma-oriented EFT, which emphasizes that processing painful emotional memories becomes therapeutically meaningful when maladaptive emotional structures are transformed through new adaptive experiences rather than merely activated or described (Kadiroğlu et al., 2026; Paivio & Pascual-Leone, 2023).

The second major finding concerned emotional inhibition. Participants receiving the integrative intervention demonstrated the greatest reduction in emotional inhibition, followed by the EFT group, while positive psychology produced a more modest reduction. This result is particularly important because emotional inhibition was one of the central themes identified during the qualitative phase. The women frequently described pressure to conceal emotional vulnerability because they feared being perceived as weak by their children or judged negatively by others. Such suppression may initially function as a protective strategy, yet persistent inhibition can restrict emotional processing, reduce opportunities to receive social support, and intensify internal distress. Previous Iranian research has demonstrated the psychometric relevance of emotional inhibition as a distinct construct and has shown that emotional inhibition can play a mediating role between emotional awareness, stressful life events, and posttraumatic stress symptoms (Asadollahi et al., 2022, 2024). Therefore, the substantial reduction observed in the integrative and EFT groups may represent an important therapeutic mechanism rather than merely a secondary outcome.

The superiority of EFT-oriented conditions for emotional inhibition can also be explained by the experiential nature of the intervention. EFT encourages clients to approach rather than avoid internal emotional states and provides structured opportunities for expressing previously inhibited emotions

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in a psychologically safe context (Greenberg, 2017). Techniques such as the two-chair dialogue allow self-critical and vulnerable parts of the self to be expressed directly, while empty-chair work provides an opportunity to articulate unresolved anger, grief, fear, disappointment, or unmet needs toward significant others. Such procedures can weaken habitual avoidance and increase tolerance for emotional activation. Therapeutic approaches designed for emotionally inhibited and fearful individuals similarly emphasize that emotional suppression is often maintained by beliefs that expression is unsafe, unacceptable, or likely to produce rejection; corrective therapeutic experiences are therefore needed to challenge these assumptions (Fassbinder & Arntz, 2019). The integrative package may have enhanced this effect by combining emotional exposure and expression with self-compassion, gratitude, benefit finding, and strength recognition, thereby reducing the likelihood that emotional openness would be experienced merely as vulnerability.

The third major finding was that character strengths increased significantly in all active intervention groups, with the greatest improvement observed in the integrative condition, followed by positive psychology, EFT, and the control group. The comparatively stronger performance of positive psychology over EFT on this outcome is theoretically expected because character strengths were explicitly targeted in the positive-psychology protocol. Participants identified their principal strengths, examined how these strengths had previously been used during adversity, and developed ways of applying them more intentionally in daily life. Such procedures may have been particularly important for women heads of household because the qualitative findings indicated that many participants possessed considerable perseverance, patience, courage, responsibility, and caregiving capacity but did not consciously conceptualize these attributes as strengths. The availability of a psychometrically supported Persian assessment of character strengths further highlights the relevance of this construct within the Iranian cultural context (Sharifi Ardani et al., 2025).

The superiority of the integrative intervention on character strengths may be explained by the fact that emotional processing created conditions for more credible and personally meaningful strength recognition. For individuals with histories of trauma, merely identifying positive characteristics may not be sufficient if their self-concept remains dominated by shame, guilt, unresolved grief, helplessness, or self-criticism. Through EFT techniques, participants were first encouraged to confront painful emotional experiences and recognize unmet needs. Positive-psychology techniques could then be used to reinterpret survival and coping behaviors as evidence of perseverance, courage, kindness, perspective, or hope. This sequence may have transformed character strengths from abstract positive labels into lived psychological resources. Such an interpretation is consistent with findings showing that psychological empowerment interventions improve well-being and quality of life among women heads of household by strengthening perceived personal capacities and adaptive functioning (Rezaeian et al., 2018; Torabi Momen et al., 2017).

The fourth major finding concerned posttraumatic growth. The integrative intervention produced the greatest increase in posttraumatic growth, followed by positive psychology and EFT, whereas only minimal changes occurred in the control condition. The stronger performance of positive psychology relative to EFT on this variable is understandable because positive-psychology techniques directly targeted several dimensions associated with posttraumatic growth, including appreciation of life, new possibilities, personal strengths, relationships, hope, gratitude, and meaning. Previous research has similarly shown that positive-psychology interventions can increase posttraumatic growth while reducing psychological distress among individuals who have experienced major adverse events (Malekpour Golsafidi et al., 2022). Positive-psychology interventions have also been effective in enhancing psychological well-being more broadly, supporting the proposition that strengthening positive emotional, cognitive, and interpersonal resources can produce meaningful changes beyond symptom reduction (Yaghoubi Abolghasem, 2019).

The stronger effect of the integrative intervention on posttraumatic growth can be explained by the combination of emotional processing and positive reconstruction. Posttraumatic growth does not simply result from thinking positively about trauma; it typically requires engagement with the meanings, losses, identity disruptions, and emotional consequences of traumatic experience. In the present intervention, participants first addressed unresolved emotional experiences through techniques derived from EFT and subsequently engaged in narrative reconstruction, benefit finding, gratitude, hope, meaning-making, positive relationships, altruism, and self-transcendence. This therapeutic progression may have enabled participants to move from painful emotional processing toward a more

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coherent and growth-oriented interpretation of their experiences. Contemporary EFT models for complex trauma similarly emphasize that adaptive transformation occurs when painful traumatic emotional structures are accessed and reorganized through new experiences of self-protection, self-compassion, agency, and connection (Kadiroğlu et al., 2026; Paivio & Pascual-Leone, 2023). Trauma-focused emotion-focused interventions have also been associated with improvements in quality of life and self-compassion among women with histories of sexual trauma, supporting the broader applicability of this mechanism to trauma-exposed female populations (Shirinkam & Rostamnejad, 2026).

The findings can also be interpreted from a relational perspective. Many trauma-exposed women experience disruptions in trust, emotional security, and expectations regarding the availability of support. Attachment theory proposes that repeated experiences within significant relationships contribute to internal expectations concerning whether others are accessible and whether one's own emotional needs are legitimate and worthy of response (McLeod, 2024). The group-based format of the present intervention may therefore have provided more than an opportunity to learn psychological techniques. It may also have offered participants a structured interpersonal environment in which emotional expression was normalized, painful experiences were acknowledged without judgment, and individual strengths were recognized by others. These experiences may have contributed to greater emotional openness and a stronger sense of interpersonal safety, thereby supporting both emotion-focused and positive-psychology processes.

The current findings are also consistent with evidence demonstrating that psychotherapy can produce sustained benefits among women exposed to interpersonal violence and other traumatic experiences (Foschiera et al., 2024). The maintenance of improvement at the three-month follow-up in the present study is particularly noteworthy. Although some attenuation was observed from posttest to follow-up, scores in the integrative group remained substantially better than baseline across all four outcomes. This pattern suggests that the intervention may have generated skills and psychological changes that continued beyond the active treatment period. Techniques such as emotional self-monitoring, adaptive expression, character-strength application, gratitude exercises, hope-based planning, and narrative reconstruction are potentially transferable to everyday life and may therefore contribute to maintenance of therapeutic gains.

The relative pattern of findings across the three active interventions is theoretically informative. EFT produced stronger effects than positive psychology on emotional self-regulation and emotional inhibition, whereas positive psychology produced stronger effects than EFT on character strengths and posttraumatic growth. This pattern suggests a degree of outcome specificity. EFT appears particularly well suited to modifying maladaptive emotional processes, while positive psychology appears particularly effective for strengthening positive resources and growth-related outcomes. Previous studies demonstrating the effectiveness of EFT for emotional and relational adjustment (Izadi, 2023; Naderian et al., 2022; Najafi, 2016) and the effectiveness of positive psychological interventions for well-being and posttraumatic growth (Malekpour Golsafidi et al., 2022; Yaghoubi Abolghasem, 2019) support this interpretation. The fact that the integrative package produced the strongest outcomes across both domains therefore suggests that these two approaches may operate through complementary rather than redundant therapeutic mechanisms.

5. Conclusion

Overall, the findings support a multidimensional conceptualization of intervention for trauma-exposed women heads of household. These women may need more than symptom reduction, just as they may need more than encouragement to focus on strengths. An intervention that emphasizes positivity without first creating space for grief, anger, shame, fear, and unresolved relational injury may risk overlooking the emotional consequences of trauma. Conversely, an intervention focused exclusively on painful emotional processing may not sufficiently support future orientation, hope, meaning, personal strengths, and identity reconstruction. The present integrative package sought to address both requirements by moving from emotional awareness and safe expression to deeper processing and transformation and then toward strengths, hope, meaning, relationships, and posttraumatic growth. The superior outcomes observed in the integrative group provide preliminary support for this sequential and complementary therapeutic logic.

6. Limitations and Suggestions

Several limitations should be considered when interpreting the findings. The study was conducted among

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women heads of household receiving services from a single empowerment center in District 2 of Tehran, which may limit the generalizability of the findings to women living in other regions, rural communities, or different socioeconomic and cultural contexts. The final quantitative sample was relatively small, with 15 participants in each group, and although substantial intervention effects were observed, larger samples would provide more stable estimates of treatment effects and permit more detailed subgroup analyses. Attrition also occurred during the study, and the final analyses were based on participants who completed the required assessments, which may have introduced attrition-related bias. Most outcomes were measured through self-report instruments and may therefore have been influenced by social desirability, response tendencies, or participants' expectations concerning treatment. The follow-up period was limited to three months, preventing conclusions regarding longer-term durability. In addition, all interventions were delivered by the same researcher, which improved procedural consistency but may have introduced therapist-related expectancy effects. Finally, because the integrative package contained multiple therapeutic components, the design could not determine which specific techniques were most responsible for the observed effects.

Future studies should replicate the present findings with larger and more geographically diverse samples of women heads of household and include participants from different socioeconomic, educational, cultural, and family backgrounds. Multicenter randomized controlled trials would provide stronger evidence regarding the effectiveness of the integrative package and reduce the influence of setting-specific characteristics. Longer follow-up periods, such as six months or one year, are recommended to examine the durability of treatment effects. Future research could also use intention-to-treat analyses and strategies for handling missing data to reduce the potential impact of attrition. In addition to self-report measures, behavioral indicators, clinician ratings, physiological indices of emotional regulation, and qualitative follow-up interviews could provide a more comprehensive assessment of change. Dismantling studies could examine the relative contribution of specific components, such as two-chair work, emotional-expression training, character-strength identification, gratitude, or hope-based goal setting. Mediation analyses may also clarify whether changes in emotional inhibition, self-regulation, character strengths, or meaning-making explain subsequent improvements in posttraumatic growth. Finally, future studies could compare the present package with other trauma-focused or third-wave interventions and examine whether participant characteristics, such as trauma type, time since trauma, attachment pattern, or severity of baseline emotional inhibition, moderate treatment response.

The findings suggest that counseling centers, municipal empowerment services, social-work organizations, and community mental-health programs serving women heads of household may benefit from incorporating structured trauma-informed interventions that address both emotional difficulties and positive psychological resources. Practitioners should create a safe and nonjudgmental therapeutic environment before encouraging clients to engage in strength-based or future-oriented exercises, particularly when shame, grief, anger, or emotional suppression are prominent. Emotional-awareness exercises, two-chair and empty-chair techniques, adaptive emotional-expression training, and emotion-regulation strategies can be combined with character-strength identification, gratitude, hope, goal setting, meaning-making, and posttraumatic-growth exercises within a staged intervention. Group delivery may be especially useful because it can reduce isolation, normalize emotional experiences, and provide opportunities for mutual validation and strength recognition. Practitioners should nevertheless adapt the pace and intensity of trauma-related exercises to the client's readiness, trauma severity, and available social support. Training counselors and social workers in the integrative protocol may also help community-based services move beyond purely supportive counseling toward more structured psychological empowerment for trauma-exposed women heads of household.

Authors' Contributions

Authors equally contributed to this article.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

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The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

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