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The Effectiveness of Compassion Focused Therapy on Depression and Rumination after Romantic Relationship Breakup: A Single Case Study

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Abstract
The purpose of the present study was to investigate the efficacy of compassion-focused therapy on Depression and Rumination after a romantic breakup. The present study was carried out using the single-case quasi-experimental method and a simple baseline method. For this purpose, three female participants were selected through targeted sampling and they were treated through an individual Compassion-focused Therapy (CFT) during eight 90-min sessions. Participants completed the Beck Depression Inventory (BDI-II) and Rumination (RRS) questionnaires in the baseline stage (pre-treatment) during the second, fourth, sixth and eighth sessions, and in the one-month follow-up stage. Moreover, in the pre-treatment stage, the participants completed the Love Trauma Inventory (LTI) and the MMPI-2RF questionnaires to identify the severity of disturbance after breakup and to detect the serious disorder in axis, respectively. Then they were interviewed in order to identify their personality disorder. For data analysis, clinical significance method and the recovery percentage index were used. The results showed that compassion-focused therapy has a significant effect on the reduction of Depression and mental Rumination. The percentage of non-overlap data (PND) on the Depression Scale was 100 for the first and second participants and 75 for the third participant; it was 100 on the rumination scale for all three participants. The rate of recovery of depression in the first, second, third participant was 65%, 72%, 25%, the rumination rate in the first, second, third participant was 47%, 42%, 33%, respectively. Therefore, it can be concluded that people who experienced a breakup after a compassion-focused therapy look at themselves with a new and compassionate look at their own.

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Introduction

There is a well-known quote by Carl Jung as “The meeting of two personalities is like the contact of two chemical substances: if there is any reaction, both are transformed” (Jung, 1955, Brunson, Øverup & Acitelli, 2019). Indeed, it is believed that the interaction with others, especially when it comes romantic relationships, helps people shape their attitude about themselves, others and the world around them. It has been shown that close relationships have a profound impact on individuals' sense of well-being. For example, close relationships are a primary source of happiness and satisfaction for individuals (Burscheid & Reis, 1998). However, relationships are not always successful, and research has shown that relationship breakup has a strong negative impact on people. For example, relationship breakup has been named as a common traumatic event that many people may experience (Anders, Frazier, & Shallcross, 2012).

The romantic relationship dissolution has more significant adverse effects on the social performance of young people (adolescents and adults under the age of 25) than other stressful factors. Research has shown that 65% of students with academic failure decide to leave University due to non-academic reasons, including difficulty in making friends and breaking up with their partner (Hendy, Can, Joseph & Scherer, 2013). The dissolution of a romantic relationships can be an interpersonal problem, boost the feelings of worthlessness and dropout, and undermine the personal competence to establish romantic relationships in the future (Connolly & McIsaac, 2009; Furman & Schaffer, 2003; Moore, Leung, Karnilowicz, & Lung, 2012). For some youths, romantic breakup may be linked to positive outcomes, such as post breakup growth (e.g., Lewandowski & Bozzuto, 2007; Moore et al., 2012; Tashiro & Frazier, 2003). However, for most people, it may be associated with severe and adverse consequences such as avoidance of communication, aggression, lack of performance, and self-destructive behaviors (Nikoogoftar, Santana, Ahmadi, Ramak, 2018). Destructive thoughts, sleep disturbances, high levels of anxiety are associated with these symptoms, which are similar to those experienced during depression and discouragement (Field, Diego., Pelaez, Deeds & Delgado, 2009)

Depression after a romantic breakup is associated with great difficulties and even higher possibility of increasing suicidal tendencies. Mental rumination can be considered as a coping strategy for depression and anxiety. Depressive symptoms have also been linked to rumination and, in particular, have been identified as an increased risk for complicated grief (Eisma et al., 2015). It might be because people with mental rumination have typically an inconsistent and overly focused attention on negative thoughts and feelings about past events (Nolen-Hoeksema & Davis, 2000, Andrade, Alcázar-Olán, Matías, Guerrero, & Espinosa, 2017). Therefore, rumination about perceived consequences of failure intensifies over time until the goal is abandoned or obtained. However, because the relational goal is now linked to a higher-order one, the goal is unlikely to be abandoned easily (Foshay & O'Sullivan, 2019). Moreover, the findings suggest that one of the most important factors in the development of depression and mental rumination is the exposure to stressful events, such as losing the favorite person or the loved ones (Nolen-Hoeksema & Davis, 1999). According to the researchers, people with high level of mental rumination were more likely to lose their loved ones during the period when they showed higher levels of depressive symptoms 18 months later than those low level of rumination (Natashia, Sepehri Shamloo, Salehi & Mashhadi, 2018).

Besides, depressive symptoms are to some extent associated with mental rumination, which also has been identified as a risk factor in weaker regulation after a relationship dissolution (Wrape, Jenkins, Callahan, & Nowlin, 2016). Young people typically experience less distress when they do not feel personally responsible for the breakup in the relationship (Chung et al. 2003) and when the reasons for the breakup are clear (Barutcu Yildirim and Demir 2015). Distress and less ability to "move on" when adjusting to a breakup have been linked to individuals' interpretation of the reason for the relationship dissolution. If they are unsure, young people often ruminate on the negative experiences associated with the breakup, allowing the distress to persist into the future (Kansky, Ruzek, & Allen, 2017).

Generally, in contrast to the storybook notion that romantic relationships are "happily ever after," relationships often generate and produce great distress in the process. As is the case for many other stressful factors in life, the challenges for people facing a romantic

breakup include confronting the breakup with resilience and moving forward with a positive attitude, especially among those who believe they are responsible for the end of the relationship. The previous findings suggested that, among such individuals, having greater compassion towards the self can promote more adjustment and growth responses to a breakup (Zhang & Chen, 2017)

Based on the nature of current problems, therapists can also help clients use a variety of common therapies. Research evidence shows that many interventions have been made on the issue of relationship dissolution. For instance, these treatments for love trauma have been approved: cognitive-behavioral therapy (Rajabi & Alimoradi ,2018), transactional analysis (Rajabi & Nikpoor ,2018), Logo therapy (Dakoda & Popal,2015), emotion focused therapy (Akbari, et al,2016), acceptance and commitment therapy (Noormohamadi, Arefi, Afshaini, & Kakabaraee,2019), Schema Therapy (Mouchan, Bahmani & Askari,2016), short–term anxiety-regulating psychotherapy (Dehghani,Atef-Vahid, & Gharaee,2011), forgiveness therapy (Amiri, Moslemifar, Showani & Panahi, 2020), Spiritual-religious Psychotherapy (Behdost, Kargar, Ziaaddini & Salimi,2019), Reality Therapy (Tavasoli, Aghamohammadin Sherbaf, Sepehri Shamloo, , & Shahsavari,2018), and Well_Being Therapy (Ahmadpour Dizaji, Zahrakar, Kiamanesh,2017). The most distinct feature of the current research compared to the most of the studied researches is the therapeutic approach through which the intervention is administered. In the current research, researcher has used CFT. Since previous researches have extensively used either absolute cognitive or emotional focused approaches, the CFT has a distinct approach toward affective grief and has a lot of emphasis on emotional systems of the brain and has considered cognitive factors as well. Opposed to the other treatments that focus only on content or process, compassion focused therapy with evolution view addresses to all aspects of the issue. Additionally, a treatment which its main feature is establishing a kind and safe context to experience difficult emotions may be effective as people experience self-blame, shame, and critics extensively following a break-up. On the other hand, most of the previous researches had group experimental design and because talking about break-up might be difficult for people it was decided to administer CFT individually to facilitate clients talking about their feelings.

Due to the fact that suffering is a defining experience in human social life, compassion has been considered as a prototypical response to suffering associated with a wide range of conditions including abuse and neglect, poverty, illness and disability (Lee & James, 2013; MacBeth & Gumley, 2012; Stellar, Oveis, Cohen, & Keltner, 2015). According to Dalai Lama, compassion is sensitivity to the suffering of oneself and others, with a deep wish and moral commitment to relieve the suffering (Stuntzner, 2017). This is clearly stated in the Western and Eastern spiritual traditions (Gilbert et al., 2014; Jazaieri et al., 2014). From the Buddhist perspective, compassion is one of the four motivational qualities of immeasurable importance (Dzwonkowska & Zak Lykus, 2015; Mongrain, Chin, & Shapira, 2011). (a) attentional sensitivity to and awareness of suffering in oneself and others; (b) sympathetic care and concern related to being emotionally moved by the observation of distress and pain; (c) nonjudgmental desire to see the relief of hurt and injury; and (d) readiness and commitment to alleviate the suffering and the offering of helpful interventions to address it in a patient and emotionally warm manner (Allen & Leary, 2010; Pepping et al, 2017).

Over the recent literature, the concept of self-compassion, as a means through which people can pursue greater personal well-being, has received substantial clinical and research attention (Batts Allen, Barton, & Stevenson, 2015; Boersma, Hakonson, Salomonsson, & Johansson, 2014). Research on self-compassion is relatively new in psychology, spanning a little over a decade. For instance, Neff (2003) defined self-compassion as being composed of three components: self-kindness versus self-judgment, a sense of common humanity versus isolation, and mindfulness versus over-identification when confronting negative self-relevant thoughts and emotions. These components combine and mutually interact to create a self-compassionate frame of mind.

In this regard, Paul Gilbert developed compassion-focused therapy (CFT) over the last 20 years, and its theoretical underpinning draws upon evolutionary psychology, attachment theory, and applied psychology processes from neuroscience and social psychology (Gilbert, 2010). CFT focuses on two psychologies of compassion. The first psychology is a motivation to engage with suffering, and the second psychology is focused on action, specifically acting to help

alleviate and prevent suffering. The aim of CFT is to provide psychoeducation on the human mind, specifically concerning its three-basic emotion-regulation systems: (1) the threat/self-protect system, (2) the drive–reward system, and (3) the soothing system. CFT emphasizes how people tend to find themselves trapped between the threat and reward systems, which can often bring about a sense of failure and high levels of self-criticism and shame (Gilbert, 2014). The affiliative/soothing motivational system helps facilitate compassion, and exercises are incorporated to make this the organizing/motivational system for the person.

In fact, CFT uses a 'not your fault' approach to help clients appreciate that we are socially shaped, and like the loops that can form between our old and new brains, our emotion systems are textured by our experiences in life. Helping clients struggling with trauma and shame experiences to understand how both the origin and maintenance of their problems are understandable can be an important step in bringing compassion to one's experience. However, the three-emotion system model also provides a basis of change, and in particular, with attempts to help clients manage their threat systems in helpful ways, often by learning how to bridge out of this and in to using the soothing-affiliative system to regulate their difficulties and distress. Much of this involves a "de-shaming" process, recognizing that many of our difficulties in life were not of our choosing and over which we had little control, but that taking responsibility for how we can learn new ways of managing our distress is central to developing compassion for oneself (Irons & Lad, 2017). Also, lots of research has shown that people who experience a period of depression have less levels of self-compassion (Baker, Caswell, & Eccles, 2019; Krieger, Alten Stein, Betting, Doering, & Holtforth, 2013; Krieger, Berger, & Holtforth, 2016).

It should be noted that CFT is a relatively "young" psychotherapeutic approach, and the evidence base for its use in a variety of difficulties is growing (Leaviss & Uttley, 2014), with particular approaches and models emerging to work specifically with PTSD and trauma (Lee, 2011; 2013). However, there are some studies in terms of the outcome of CFT with trauma populations. For example, Beaumont, Galpin & Jenkins (2012) found that trauma clients receiving CBT, or those receiving a combined treatment of CBT and CMT (compassionate mind training) skills, both experienced significant

reductions (and of a similar magnitude) in symptoms of anxiety, depression, avoidant behavior, intrusive thoughts and hyperarousal symptoms post therapy. However, participants in the combined CBT and CMT treatment reported significant higher self-compassion scores than those just receiving CBT. Since compassion focused treatment uses techniques and principles which are specifically trauma related (e.g., rewriting, exposing to difficult emotions) and techniques which address to self-critics and shame (e.g., empty chair, writing a letter, forms of thought), so we can consider CFT as an integrative approach which uses components of self-compassion and leads to clients improvement. As mentioned earlier, affective traumas play an important role in damaging mental health of people and youths in particular and if left untreated, it can have aversive outcomes such as academic failure, parole, dropout, social breakdown, and even sometimes suicide. If the person is not capable of coping with the break-up and cannot adjust, it would lead to aversive outcomes in all aspects of her/his life thus the main question of the current research is the effectiveness of compassion focused therapy on depression and thought rumination after break-up.

In this regard, the study conducted by Wang, Chen, Poon, Teng and Jin (2017) indicated that cognitive compassion-focused therapy has a significant effect on reducing aggression, impulsivity, guilt, and shame caused by substance abuse. Self-compassion-Focused Programs (Gilbert, 2009; Neff & Garmer, 2013) are designed to cope with difficult emotional situations in a way that through the development of self-compassion during stressful times potentially can reduce the risk of secondary trauma and burnout, and consequently increase individual well-being and compassionate satisfaction simultaneously (Beaumont, Durkin, Martin, & Carson, 2016).The effectiveness of this treatment has been studied in some randomized and controlled experiments. In this regard, also some previous research has investigated the effects of compassion-focused therapy on reducing negative emotions and pessimistic thoughts and self-esteem (Lincoln, Hohenheim & Hartmann.2013, Imrie & Troop, 2012) and reducing stress and reinforcing the feeling of calmness and relief (Heriot-Maitland, Vidal, Ball & Irons, 2014)

It should be pointed out in compassion-focused therapy (CFT), the techniques and principles that are implemented are specifically related

to trauma (rewriting, exposure to difficult emotions and self-critical) and other issues (chair work, letter writing, thought forms). Therefore, it can be considered as an integrated approach that, beside the other psychotherapeutic approaches, applies the features of self-compassion and facilitates the client's recovery. Thus, the main question of the research is whether compassion-focused therapy is effective in reducing depression and mental rumination in people after the breakup of a romantic relationship.

Method

This study was conducted through the single-case experimental method, in particular, AB design which involves repeated measurement of outcome variables throughout a baseline control or comparison phase (A) and then throughout an intervention phase (B). The reason for using this design in the current research is unavailability of large size of sample at the time of the study and also that the compassion focused therapy is a relatively new treatment and single case designs afre often used t examine the effectiveness of new treatments. The study population consisted of all young girls who had recently faced a romantic relationship breakup in Isfahan in 2018. The participants were selected based on available sampling method. Through a call for participation on social networks, young girls with experience in a romantic relationship breakup were invited to take part in a research project at the Counseling Center of University of Isfahan. The participants completed the love trauma Inventory (LTI) and the MMPI-2RF questionnaires to identify the severity of disturbance after breakup and to detect the serious disorder in axis, respectively. After screening participants based on inclusion criteria, three qualified female students were selected out of 65 volunteers for entering the research with the criteria of experiencing a romantic relationship breakup. Then, one week before intervention and in pre-treatment phase, the participants completed Beck Depression Inventory (BDI-II) and Rumination (RRS) questionnaires scored on a four-point Likert scale in the baseline stage. Then, participants were treated through an individual compassion-based treatment (Irons & Beaumont, 2017) during 8 weekly sessions (90 minutes each). The questionnaires were also administered during treatment phase at the second, fourth, sixth and eighth sessions. During one-month follow-up stage, the questionnaires were administered with one-week intervals. Because of difficulty in accessing the subjects after

finishing the treatment and also reviewing researches, the follow-up was performed after one month (Najjarpoor Mohammadabadi, Ghanbari Hashemabadi, & Mazaheri, 2017).

The main inclusion criteria for the research included being 18-30 years old (the reason for choosing this range was the peak of romantic relationships and tendency to have date and experience romantic relationships), having the experience of a romantic relationship at least for 6 months to one year, having the experience of unwilling breakup of the relationship, not being in another relationship with someone else, spending at least three months from the end of the relationship, obtaining a score of between 20 to 30 in Love Trauma Inventory. On the other hand, the exclusion criteria were the diagnosis of serious and problematic psychological disorders (axis I & II) (for example, psychosis, bipolar disorder, substance dependency and personality disorders) assessed based on semi-structured interviews and MMPI-RF2 Test, going through the full course of psychotherapy or medication, having a serious suicide attempt that requires crisis intervention, attempt to resume a relationship, history of drug and alcohol use, being absent in more than 2 sessions, and failing to do the tasks. Considering the design of the present study, the visual analysis was applied to report and explain results. In this formula, the pretest score was subtracted from the post-test score and the result was divided into the score of pretests. According to Blanchard formula, a 50%-improvement is significant and is considered as success in therapy, 25-49% one is considered as an average improvement and improvement below 25% is known as failure in therapy (Hamid pour, Dolatshahi, Pour Shahbaz, Dadkhah, 2011). Also, if an individual's score is lower than cut-off score after treatment, it will be significant clinically. Blanchard formula is as following: A0= Obstacle problem in the beginning of therapy, A1= Obstacle problem in the end of therapy and A%= improvement. A%=A0-A1/A0

In order to follow the ethical considerations of the research, voluntary attendance at the consultation sessions and obtaining full informed consent to participate in the sessions, full expression of the implementation method, the purpose of the research, possible losses, benefits, nature and duration of the research to the subjects and convincing answers to their questions, passing the training courses "Compassion Focused Therapy" and "Romantic Break-down" by the

researcher and obtaining scientific and practical approval under the supervision of the supervisor, free sessions, lack of harm to the subjects and any required compensations in case of injury were considered.
Measures: Love Trauma Inventory (LTI). This questionnaire was designed by Ross (1999) to measure love trauma and consisted of 10 four-choice items. This questionnaire provides a general assessment of the extent of physical, emotional, cognitive, and behavioral impairment. The minimum score for this test is zero and its maximum score is 30. Score 20 has been considered as the cut-off score in this questionnaire. The coefficient of internal consistency of this test has been reported equal to 0.81 and its reliability coefficient in Iran was obtained equal to 0.83 through re-test method during a one-week interval. Dehghani (2011, cited in Amanelahi, et al., 2016) reported the validity of LTI as $r = .64$ and its reliability as $\alpha = .85$.

Minnesota Multiphasic Personality Inventory (MMPI-2). This questionnaire consists of 50 scales that have different subscales including 8 validity scales, 3 restructured scales, 9 clinical scales, 25 content component scales, special problems and the personality psychopathology five (PSY-5) scales. This test is designed in 338 questions with two option with zero key and one raw score is converted to balance scores to observe lack of elevation, mild elevation and severe elevation. The mentioned test has been standardized by Kamkari and Shokrzadeh (2013) in Iran. These 338 questions can be immediately rated through advanced software and can be provided in five separate profiles for each participant in order to give guidance and counseling services.

Beck Depression Inventory-II (BDI-II). BDI-II is a 21-item test on a four-point scale from point 1 to 4, which has been developed for assessing the severity of depression symptoms. This is a self-reported questionnaire with a 21-point scale to assess physical, behavioral and cognitive symptoms of depression. Each item has four options that are rated as 0-3 to determine different degrees of depression from mild to severe. The overall score of this scale is the sum of scores of all questions where score from 0 to 10 represents minimal depression; score 10 to 20 represents mild depression; score 20 to 30 indicates moderate depression; score 30 to 40 represents severe depression; and score above 40 indicates more severe depressive symptoms. The internal consistency is from 0.3 to 0.92 in the original version of this measurement. In the Iranian version, for psychiatric outpatients the

coefficient was calculated as 0.92, the reliability as 0.93 and the validity from 70% to 90% (Fathi-Ashtiani & Dastani, 2009).

Ruminative Response Scale (RRS). The scale consists 22 items that its items are rated on a 4-point scale from one (almost never) to four (almost always). This scale's range is 0.88 to 0.92 through Cronbach's alpha that represents internal consistency of this scale. Intra-class correlation has been reported 0.70 for five times measuring. In addition, the test-retest correlation has been reported 0.67 for more than 12 months. Cronbach's alpha obtained in the Iranian sample by Mansouri (2009), is reported 0.90. Bagherinezhad, Salehi Fadardi, and Tabatabayi (2010) translated the scale into Persian and reported its reliability as α = .88.

A researcher made therapeutic package based on *compassionate mind* workbook (Irons & Beaumont, 2017) was used to administer the CFT. The current design of treatment was verified by two specialists in compassion area, then a pilot study was performed and some parts of the design were localized with Iranian community. Consequently, validity and reliability of the current protocol were confirmed. After edition, the final version was performed on the main sample. The 8-session protocol is presented below briefly (table 1).

Table 1. Sessions of Compassion Focused Therapy

Session	**Therapy objectives**	
First	Familiarity and therapeutic unity	Reporting and identifying the details of the relationship process and disconnecting and creating a sense of security, CFT motivational interview Description of the evolutionary foundations of compassion theory and life scenario
Second	formulation in CFT	background/experiences, common fears and threats, common protective and safety strategies, common unintended consequences, Bringing compassion to formulation
Third	Understanding our emotions	Cultivating the soothing system, Body and breathing focus Cultivating the soothing system, Using imagery and memory Building the drive system, threat and self-protection system
Fourth	The three flows of compassion and Working with common difficulties	Attention and mindfulness، Creating an image of your ideal compassionate other Compassion in the mirror fear of compassion and complex emotions
Fifth	Examine self-critical coping styles	Attention and mindfulness Developing our compassionate self Listening to and validating self-criticism

		Metaphor Two teachers Changing shame-based self-criticism to compassionate self-correction
Sixth	multiple selves and emotion	Attention and mindfulness Compassionate engagement of emotion Understanding and bringing compassion to multiple selves Metaphor of the ship's captain
Seventh	Evaluate and identify compassionate skills	(Attention, thinking, feeling, emotion, behavior) Compassionate letter writing
Eighth	Review and summarize and end the session	manage fears, blocks or resistances to compassion

Results

The demographic characteristics of the subjects are shown in table 2.

Table 2. Demographic Characteristics of Clients

Client	Age	Education	Previous treatment	Relationship period	Ending period	LTI Score
Client1	20	Undergraduate student	No	6 months	7 months	20
Client 2	21	Undergraduate student	Yes	10 months	12 months	23
Client 3	24	Masters student	Yes	6 months	8 months	21

According to the table 2, the first subject was a 20-year old, first child, BA female student who was engaged in a romantic relationship for 6 months with the aim of marriage. Their initial dating was in a party and by the boy's proposal. The reason for the break-up has been cited as personality problems of the romantic partner. Also, the break-up was on the part of the partner. The client suffers from feelings of guilt, anger, depression, anxiety, and hatred after the relationship breakdown. The client had well academic-social performance prior to the relationship and there were no history of psychological or psychiatric treatments. This was the client's first serious romantic engagement and its goal has been reported for marriage. The client's main complaints in beginning of the treatment were lack of self-confidence, having trouble in interpersonal relationships, depression, anxiety, insomnia, and lack of concentration. She described a cold family atmosphere and parents having family conflicts and separation. She had not good relationship

with her mother and did not have any history of psychological problems or hospital admission. The second subject was a 21-year old MA female student with upward socio-economic status who was engaged in a romantic relationship for 10 months. The relationship was broke-up by the partner and she did not know the reason exactly. Though she reported that they had lots of challenges in the last months of their relationship. It has been a year since the break-up yet she was not able to adjust herself with it and she was deeply tended to know the reason and into feeling and loving him and she stated that "I cannot love someone ever again". The client had anxiety, high heart beating, depression, and weight loss after the break-up. The third subject was a 24–year old, first child, MA female student. Their initial dating was suggested by a common friend and it lasted for 6 months with the aim of marriage by suggestion of the boy. The relationship termination was on part of the partner and without any convincible explanation. The client states that her partner had intense show of affection and that he was very persistent on getting married in a few months before the termination. But when the client gets permission from her family for proposal ceremony, the boy suddenly gives up on marriage. The client felt humiliated and rejected. The history of client's life reveals that she is emotionally dependent. Her main complaints at the beginning of the treatment were fatigue, depression, worry about future, self- and opposite sex-hatred, academic failure, low self-esteem, and frequent crying. The client reported nice affective relationship with her family and described a warm family atmosphere and she did not have any particular physical diseases. The findings of the table 3 are shown in figure 1.

Table 3. The mean, the Standard Deviation and the change trend of three participants in terms of depression variable

Information about each of three subjects' treatment process including scores and standard deviations of baseline, intervention, and follow-up are shown in table 3. Also, RCI, improvement percentage of intervention and follow-up stages and PND and POD	**First Client**	**Second Client**	**Third Client**

induces of depression are reported as well.				
Baseline	M	37.25	12	24
	SD	1.70	3.55	1.5
Post-treatment	M	13	3.25	18.75
	SD	2.58	2.87	1.00
	RCI	4.58	2.50	1.99
	Improvement level	%65	%72	%25
	Total improvement percentage		%54	
Follow-up	M	5.75	1.50	11
	SD	0.81	3.77	2.16
	RCI	2.22	1.56	1.98
	Improvement level	%53	%60	%38
	Total improvement percentage		%50	
	PND	100%	100%	75%
	POD	%۰	%۰	%۲۵

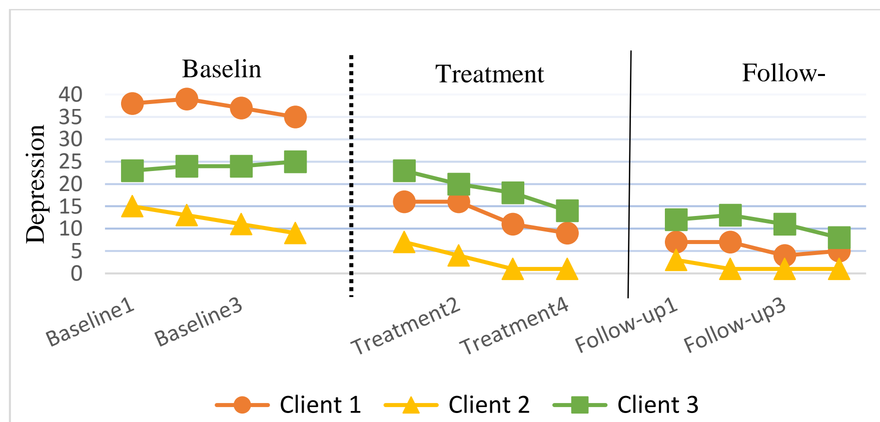

Figure 1. Changing trend of scores of total scale of depression variable at baseline, treatment and follow-up stages for three participants

As observed in Figure 1, the mean and level of depression scores have been decreased in all three subjects because of compassion-

focused therapy. In addition, according to POD in first, second and third subject, prediction lines are above the trend line (at least 3 points) and it could be stated that treatment has been effective. Also, RCIs achieved for all three subjects were 4.58, 2.50 and 1.99 in treatment phase; respectively, and they are significant in 0.05 statistical level. These amounts indicate to some changes and improvement in scores of depressions. Additionally, a 54%-total improvement percentage for all three subjects refers to a modest (proper) success in therapy in Blanchard opinion. Therefore, it can be stated that when a romantic relationship breakup occurs in Isfahan, compassion focused therapy might be effective on decreasing individuals' depression.

Information about each of three subjects' treatment process including scores and standard deviations of baseline, intervention, and follow-up are shown in table 3. Also, RCI, improvement percentage of intervention and follow-up stages and PND and POD induces of Rumination are reported as well. The findings of the table 4 are shown in figure 2.

Table 4. The mean, the Standard Deviation and the change trend of three participants in terms of Mental Rumination variable at treatment phase

		First Client	**second Client**	**third Client**
Baseline	M	72.75	55.25	60
	SD	4.5	4.89	2.44
Post-treatment	M	43	36.5	41.25
	SD	4.89	5.19	4.34
	RCI	4.40	3.30	2.25
	Improvement level	%47	%42	%33
	Total improvement percentage		%40	
Follow-up	M	19.75	21.25	32.5
	SD	2.75	2.62	3.51
	RCI	2.55	2.10	0.96
	Improvement level	%50	%55	%46
	Total improvement percentage		%50	
	PND	100%	100%	%١٠٠

POD	%0	%0	%0

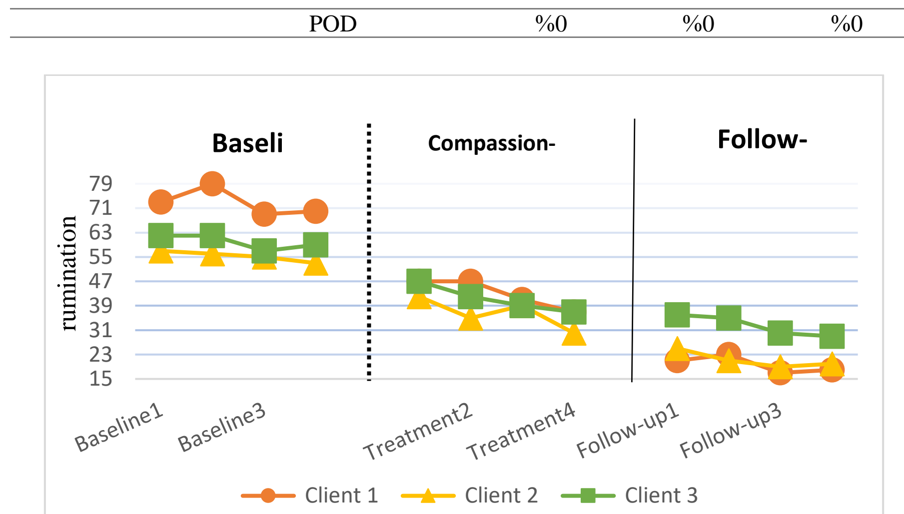

Figure2. Changing trend of scores of total scale of Mental Rumination variable at baseline, treatment and follow-up stages for three participants

As observed in Figure 2, the mean and level of rumination scores have been decreased in all three participants after compassion-focused therapy. In addition, according to POD for each of first, second and third participants, prediction lines are above the trend line (at least 3 points) and it could be stated that treatment has been effective for these three participants. Also, the indicators of reliable change were achieved as 4.40, 3.30 and 2.25 for all three subjects in the treatment or intervention phase, respectively, and they are significant in 0.05 statistical level. These values indicate changes and improvement in scores of ruminations. Additionally, according to Blanchard, a 41%-total improvement for all three subjects is considered as an average success in therapy Therefore, it could be stated that compassion focused therapy is effective on decreasing individuals' rumination in a romantic relationship breakup in Isfahan.

Discussion

The present study aimed to investigate the efficacy of compassion-focused therapy on depression and rumination after a romantic breakup. The results of this study are in line with the findings reported by Baker, Caswell and Eccles (2019), Krieger, et al (2013), Falconer.et al. (2016), Mackintosh (2016), Steindl, Matos and Creed (2018). Moreover, another study conducted by Krieger, et al (2016) showed that people

who experience a period of depression have a lower rate of self-compassion.Besides, among Iranian studies, the findings of this study are consistent with the reports by Shariati, Hamid, Hashemi ShaykhShabani, beshlideh and Marashi (2017), Fatolaahzadeh, Majlesi, Mazaheri, Rostami and navabinejad (2017). According to the theory of social evolution ranking theory, the findings of the present study suggest that compassion-focused therapy (CFT) often fails to treat people with a high level of shame and self-criticism and the history of abuse, neglect or coercion who are unable to feel immunity and equality in relationship with others (Gilbert, 2009). More importantly, shame and self-criticism create maladaptive patterns of thinking and behavior that may sustain and exacerbate negative inner states such as depression (Gilbert, 2009). More importantly, shame and self-criticism generate maladaptive patterns of thinking and behaviors that result in sustaining and intensifying the negative inner states such as depression (Gilbert & Procter, 2006). This finding is in line with research by Ghasemi, Goudarzi and Ghazanfari (2019). Throughout the literature in the area of CFT, compassion reflects specific skills and traits that foster a compassionate mind (Gilbert, 2009). Developing a compassionate mind in a specific way is a set of techniques that facilitate and raise the individual awareness of negative interactions with oneself. Over time, the self-critical attitude is replaced by an approach based on welfare care, sensitivity, empathy, tolerance, empathy, and non-judgment. Over time, the self-critical attitude can be replaced by an approach based on welfare care, sensitivity, compassion, tolerance, sympathy, and non-judgment (Gilbert, 2009). In a study by Krieger, et al (2013), in addition to the role of self-efficacy in reducing depressive symptoms showed that self-compassion is also associated with reduced intellectual rumination (which is common in people with depressive symptoms).

Moreover, the findings of this study indicated that the increase in self-compassion was associated with the reduction in avoidant coping style, and perhaps that reduction resulted in the avoidance of pleasurable and positive stimuli that formed the effect of compassion-focused therapy (CFT). According to the CFT, depression roots in self-critic and self-blame. Thus the path that clients go through in CFT includes stepping up the compassion ladder which is comprised of mindfulness exercises, relaxation breathing rhythm, safe imagination, compassionate memories, self-compassion and becoming the

compassionate other, using compassion in mirror technique and the two teachers and captain as well lead to replacement of the compassionate self with the criticizer self and reduction of depression. It should be noted that, CFT approaches are highly important in a way that they can modulate the activation of the emotional system to respond to threats and at the same time increase the relief system. Therefore, the CFT approach can generate the empowerment in individuals to move toward valuable goals.In accordance with traditional cognitive-behavioral therapy, CFT has a compassion therapy position within itself. In this sense, the major concentration in CFT is on creating and promoting compassion for oneself and others, thus reducing the self-destructiveness in depressed people and reducing their depressive symptoms. One of the crucial components in compassion-focused therapy framework is mindfulness techniques. Therefore, mindfulness can be considered as a shield against the tendency to use a negative thinking pattern, which is a threat for the symptoms of depression. In the same vein, mindfulness practices can be beneficial for health and emotion regulation (Tomlinson, Yousaf, Vitters & Jones, 2018).

Another finding of the present study was that compassion-focused therapy (CFT) can lead to the reduction in the mental rumination of people after the breakup of a romantic relationship in Isfahan. These findings can be considered to some extent in line with the study by Raes (2010) which showed that self-compassion might indirectly reduce depression by mediating mental rumination. This study indicated that the increase in self-compassion is associated with decrease in the rate of rumination, and perhaps this decrease in rumination ultimately leads to a reduction in depressive symptoms. These current findings in terms of self-compassion are consistent with those of the research conducted by Noorbala, Borjali, and Noorbala (2013) , Eslamian, Moradi and Salehi (2019). In this regard, the study by Krieger,et al (2013) showed that self-compassion is associated with reduction in rumination and avoidance. Also, in another study that was somewhat similar to the present study Johnson and O'Brien (2013) indicated that self-compassion leads to the decrease in mental rumination, feelings of shame and depression, and self-compassion tends to act as the pacifier of the rebellious ego-threatening system.

Furthermore, the present study agrees with Frostadottir and Dorjee (2019), Svendsen, Kvernenes, Wiker and Dundas (2017) in the sense that since mindfulness and its techniques play an important role in the

process of compassion-focused therapy (CFT), every individual could identify their emotional experiences and create a self-compassionate attitude toward their negative and distressing thoughts and feelings. The individuals who have gone through difficult experiences were constantly reflecting back or ruminating on past events, which can lead to physical and emotional distraught. Even a person may reflect on or think about these thoughts in themselves and having metacognitive thoughts, such as trying to avoid these thoughts, can lead to more distraught in itself. It can be suggested that training techniques based on mindfulness such as conscious breathing and body scan meditation are considered as integral part of compassion-focused therapy can raise individual's awareness toward a range of internal stimuli, including thoughts, emotions, physiological sensations, and external stimuli. Apart from the major elements in compassion-focused therapy, compassionate thinking, reasoning, behavior and imagery can be facilitated through mindfulness practices (Lad & Irons, 2017). As the CFT is based on an evolutional perspective, the client becomes familiar with complicated brain systems and the old and the new brain and emotional regulation systems and their functions and finds out that rumination is one of capacities of the new brain and specific to human which begins with activation of threads, thus the therapist specifically emphasizes on upgrading alleviation system throughout the therapy and mindfulness skills are most important techniques to upgrade the alleviation system. In fact, through mindfulness, individuals learn how to pay attention to their inner world with curiosity, kindness and lack of judgment. Consequently, they become aware of their ruminant mindsets that can lead to self-destruction, thus they can understate this cycle of ruminant, critical and self-destructive thoughts better and break them down.It is worth mentioning that the major part of the negative emotions that people experience is generated from mental ruminants that are created subsequently after negative experiences in the mind. In fact, it can be said that the variable of mindfulness can result in a decrease in negative emotion by reducing mental rumination (Hadian & Jabalameli, 2019).

Based on the findings of the study it can be suggested that rumination tends to act as an inconsistent emotion regulation strategy in which negative emotions are exacerbated because they are not effectively processed (Smith & Alloy, 2009). One of the factors that may play an

important role in facilitating emotional processing is self-compassion, , which is a kind of healthy attitude that involves compassion and understanding that failure and error are common to all human beings and do not belong only to one particular person (Neff, 2003). The attempt to reinforce self-compassion in individuals who are vulnerable in the face with cognitive style of rumination can be suggested as a potential protection strategy. Since mental rumination is conceptualized as an incompatible emotion regulation strategy which is generated from positive metacognitive beliefs to reduce the gap between the current and the ideal situation (Smith & Alloy, 2009). Therefore, implementing compassion-focused therapy can act as a protective shield and result in the reduction of rumination by softening the destructive view of oneself and normalizing failures and mistakes. As such, Diedrich, Grant, Hofmann, Hiller and Berking (2014) pointed out, compassion-focused therapy for individuals with high levels of mental rumination can act as mind physiotherapy. In other words, by stimulating the relief system, it can pave the way for its evolution, and consequently the reduction of mental rumination. Like any other research, the current one had some limitations, too. For example, the majority of the sample were female which reduces the probability of generalization of the results to males, 12 times repetition (baselines, during the intervention, and follow-up) of administrating the questionnaires to assess variations would reduce the validity of the study because of familiarization of the subjects with the concepts of the research, and using self-report questionnaires to collect the data makes the possibility that the respondents answer unreal or with distortions. One of therapeutic criteria of the research was that the subjects would not have any serious disorders of either axis 1 or 2. Thus, generalization of the results to people with disorders must be with caution. It is recommended to administer the CFT for people with romantic break-up experience and who have personality disorders as well. Three- and six-months follow-ups should be carried out in future research. Also, it is recommended to carry out models and plans of premarital education in order to prevent the problems resulting from break-up and increase people performance. Also, the CFT can be used in counseling centers with clients with personal and interpersonal problems and specifically people with romantic break-up. Given that the CFT is a new treatment in terms of research literature and lack of research in romantic break-up in local and international research literature, it is recommended to do some research in this area.

The last point that needs to be taken into account is that compassion-focused therapy is a new treatment throughout the research literature. Also, there has been a few studies regarding the issue of breakup in romantic relationship in domestic and foreign areas of research. Therefore, there is an urgent for further research in the current issue.

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