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RESEARCH ARTICLE

Emotion-focused therapy for distress-based psychopathology in adults: A systematic review and meta-analysis

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Abstract

Objective: In the current study, we review and meta-analyze the existing clinical trials of emotion-focused therapy (EFT) for treating a wide variety of distress-based forms of psychopathology, including depression, generalized anxiety, posttraumatic stress disorder (PTSD), and borderline personality symptomology.

Method: We conducted a systematic review and meta-analysis of existing published clinical trials through April 2025 of EFT for distress-based dysfunction.

Results: We located 13 existing articles ($n = 348$ participants receiving EFT; 201 receiving control) that met inclusion criteria. Most studies examined EFT for depression, while a significant number measured anxiety as an outcome, and two examined PTSD symptoms. EFT significantly outperformed inactive controls ($g = 1.39$, 95% CI = [1.06, 1.72]) but not other psychotherapies ($g = .28$, 95% CI = [−.19, .76]). Limitations of the existing research include evidence of publication bias and a strong focus on women and White/Iranian populations. Additionally, the quality of existing research is largely poor with varying methodological problems, including small sample sizes, inadequate randomization, and failure to account for dropouts.

Conclusion: EFT appears to be modestly effective for the examined concerns. Future researchers should prioritize examining EFT with more methodologically rigorous designs in more culturally and gender diverse populations.

Keywords: Emotion-focused therapy; distress disorders; depression; anxiety; PTSD

Clinical or methodological significance of this article: The current systematic review and meta-analysis aims to answer the question of how effective emotion-focused therapy (EFT) is for treating distress-based forms of psychological dysfunction. The findings suggest that EFT may be moderately effective for treating distress-based dysfunction, but the quality of the existing evidence is largely poor and at increased risk of bias, and more research is needed.

Emotion-focused therapy (EFT) is a contemporary humanistic model of psychotherapy that aims to enhance an individual's awareness of and ability to tolerate and regulate emotions (Elliott & Greenberg, 2007; Greenberg, 2010; Greenberg & Watson, 1998). Through therapist emotion coaching, the goal of EFT is to transform maladaptive emotion schemes and responses into more adaptive ones to reduce ongoing distress. Recently, EFT has been designated as an empirically supported psychotherapy for depression by the Society of Clinical Psychology (Bricker et al., n.d.). However,

a comprehensive and up-to-date systematic review of its evidence for psychopathology directly involving pervasive patterns of negative emotionality (NE; e.g., depression), as conceptualized under the Hierarchical Taxonomy of Psychopathology (HiTOP), is missing from the literature. The aim of the current study is to review and meta-analyze the existing psychotherapy clinical trial literature for using EFT for psychopathology that involves pervasive NE, such as depression, generalized anxiety disorder (GAD), trauma, and borderline personality disorder (BPD).

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Emotion-Focused Therapy

EFT harnesses emotion in helping patients overcome maladaptive patterns and develop new adaptive emotional responses. Originally developed by Leslie Greenberg and colleagues (Greenberg et al., 1993; Greenberg & Watson, 1998), EFT is based on core humanistic values, including immediacy, authenticity/genuineness, self-determination, pluralism, and growth (Elliott & Greenberg, 2007). Originally termed process-experiential psychotherapy, EFT has its roots in the integration of humanistic (e.g., person-centered therapy) and gestalt therapies (Greenberg, 2010). Importantly, EFT operates from the perspective that all emotions are adaptive and serve a function.

Key emotion-focused concepts in EFT include emotion schemes and emotion reactions. Emotion schemes are unique and idiosyncratic schemata that organize an individual's emotional experiences. Emotion reactions are essentially emotional responses to situations. The two essential emotion reactions include primary emotions (e.g., emotional response to a situation itself) and secondary reactive emotions (the emotional response to the primary emotion; Elliott & Greenberg, 2007). The overarching goal of EFT is to help patients transform maladaptive emotion schemes through emotion-focused experiential exercises, such as the two-chair technique (Greenberg, 1979).

Qualitative research has shown that EFT is effective, and patients generally find EFT to be helpful. For instance, Marren et al. (2022) synthesized results from 11 qualitative studies and identified that patients found it helpful to process emotions and that the emotional connection with the therapist was helpful. They also found that patients find some aspects of EFT both difficult and helpful (e.g., chair work and experiential exercises were found to be both difficult and helpful, and patients found experiencing some emotions as painful but helpful). However, many clients found EFT to lack a focus on coping strategies, experienced therapy as too short, or found the therapist to be too caring.

In addition to qualitative research, preliminary quantitative research has also generally provided evidence that EFT can be effective for a wide variety of presenting concerns, including trauma, social anxiety (Fülep et al., 2021), and depression (Greenberg, 2017). However, a comprehensive review of its evidence for distress-based dysfunction is lacking. The current study seeks to address this gap.

The Importance of EFT for Distress-Based Dysfunction

The current study examines the evidence from the individual psychotherapy clinical trial EFT for

individuals with problems of NE, broadly defined as depression, generalized anxiety, posttraumatic stress, and borderline personality disorder. Outcomes were anchored to these presenting concerns due to research on psychopathology classification, which has provided evidence that these four areas of psychopathology are closely related to each other (Kotov et al., 2022). More specifically, under the HiTOP framework, distress-based dysfunction is subsumed under the spectrum of internalizing psychopathology. Internalizing psychopathology includes eating pathology, fear-based disorders (e.g., specific phobia, obsessive-compulsive disorder, panic disorder), sexual problems (e.g., arousal/desire problems), and distress-based dysfunction (e.g., depression, posttraumatic stress, generalized anxiety, borderline personality).

Distress-based forms of psychopathology share features of pervasive NE (Watson et al., 2022), which are not shared with other forms of psychopathology (e.g., mania). This makes EFT a prime intervention to use with patients who present with distress-based concerns; however, a comprehensive examination of the EFT literature across distress-based issues is missing from the literature. Given that prior researchers have conducted recent systematic reviews of EFT for other forms of internalizing concerns (e.g., eating disorders; Osoro et al., 2022), it seemed most relevant to place focus on these distress-based forms of internalizing disorders, as these are dimensions of psychopathology defined by pervasive NE rather than context-delimited distress as seen in some other concerns (e.g., phobias, social anxiety, panic, obsessive-compulsive disorder).

Alongside the benefit of hopefully reducing statistical heterogeneity in outcomes, examining EFT for distress-based dysfunction is beneficial due to the specific emotional nature of such concerns. For example, depression and PTSD share features of low self-worth, shame, and hopelessness and difficulties accessing and processing such emotions. EFT is a prime intervention to address such features, as the goal of EFT is to reshape and reform emotional schemes. However, though other forms of psychopathology (e.g., bipolar or psychotic disorders) may share related features of stress, loneliness, or shame that can be targeted with EFT, their core features are not emotional distress. They also involve additional defining features such as disturbances in cognition that are not easily targeted by EFT. For example, mania involves heightened mood states due to assumed neurochemical dysregulation and nearly always requires pharmacological intervention for management (Kishi et al., 2022). Similarly, psychosis involves distortions in perception or

alterations in reality testing deriving from disturbances in cognition that may be more directly related to the processes targeted in CBT (Candelari et al., 2025). Though we do not argue that EFT is unable to help patients with these other forms of psychopathology, especially if they trigger the onset of secondary concerns such as those subsumed under distress-based dysfunction, we do believe that EFT has a more evident role to play in the treatment of distress-based psychopathology.

Prior EFT Evidence

Prior EFT systematic reviews examined the evidence for using EFT for broad-based psychological concerns, including depression, trauma, social anxiety, eating disorders, among other concerns (Fülep et al., 2021; Osoro et al., 2022). Fülep et al. (2021) examined eight published randomized controlled trials/quasi-experimental trials of EFT and found some support for EFT's use with each presenting concern, though there were few studies for nearly every concern (e.g., three for depression, one for social anxiety, two for trauma, and two for eating disorders). The authors found the strongest evidence for depression but inconsistent evidence of whether EFT was more or less effective than established psychotherapies. Additionally, the authors excluded studies of group-based EFT, focusing only on individual forms of EFT.

The inclusion of only controlled trials and individual-based interventions leaves much to be discovered about how EFT may function in different formats or what evidence exists outside of controlled trials. Additionally, Osoro et al. (2022) reviewed eight studies of individual and group therapy for EFT and found it to be effective for treating binge eating disorder, but they failed to identify significant support for other eating disorders. Though these reviews provide a preliminary base, the literature for EFT is continuing to expand, and an up-to-date review of the literature for distress-based dysfunction is lacking. This is important as research on EFT has grown in popularity globally in recent years.

Additionally, the field of clinical psychology is progressively moving away from Diagnostic and Statistical Manual-based classifications. The HiTOP model (Kotov et al., 2022) is a popular alternative framework. Reviewing EFT trials using the HiTOP as an organizing framework will give unique insights into EFT effectiveness and growth areas. The approach will also serve as a model for future researchers to evaluate clinical trials for problems with similar features. Moreover, prior reviews (Fülep et al., 2021) examined only controlled trials, which may not

fully capture the EFT evidence for a variety of concerns, as recent single-arm open trials have also been published (e.g., Kramer et al., 2026; O'Connell Kent et al., 2021), and the RCT literature is also rapidly increasing (Amirshahi et al., 2024; Dehnavi et al., 2024; Salarirad et al., 2022). We aim to provide a comprehensive and up-to-date review and perhaps the first meta-analysis of the literature for using EFT with distress-based dysfunction.

The Current Study

The purpose of the current study is to systematically evaluate and meta-analyze the existing evidence for individual and group-based EFT with distress-based dysfunction related to pervasive NE: depression, generalized anxiety, posttraumatic stress, and borderline personality. We used the following aims to guide the current investigation:

Aim 1: Synthesize, in both qualitative and quantitative manners, the available treatment response evidence for using EFT to treat distress-based internalizing psychopathology.

Aim 2: Identify EFT clinical trial growth areas in the literature and propose future directions for EFT researchers by summarizing the quality of the current literature and identifying existing gaps for specific patient populations and presenting concerns.

Method

Search Strategy

We used the following databases through March 2025 to locate relevant literature: PubMed, PsycInfo, Embase, Scopus, and Cochrane. These databases were chosen due to their broad coverage of psychotherapy trials and coverage of international literature. Each search contained the terms "emotion-focused" and "therapy" to locate EFT research. To locate research related to depression, we used the following search terms in combination with the EFT terms: "major depressive disorder" or "persistent depressive disorder" or "premenstrual dysphoric disorder" or "depression" or "depressive symptoms." To locate research related to generalized anxiety, we used "anxiety" or "generalized anxiety disorder." For PTSD, we used "posttraumatic stress disorder" or "traumatic stress" or "trauma." Finally, for BPD, we simply used "borderline personality disorder." Additionally, after completing the database search, we reviewed the references of a recent (Fülep et al., 2021) systematic review of randomized

controlled trials of EFT and included any which met inclusion criteria for the current study.

Inclusion/Exclusion Criteria

We utilized the following inclusion criteria: (i) human subjects research, (ii) the study must have focused on adults, (iii) it must have been an intervention study of individual or group EFT, (iv) the study must have tested a standalone EFT intervention, and (v) the study must have included outcome data on depression, anxiety (generalized anxiety but no other anxiety disorders), PTSD, or BPD symptoms. Studies with the following characteristics were excluded: (i) studies focused on youth < 18 years old, (ii) integrative or additive interventions (e.g., integrating EFT components with cognitive-behavioral therapy), (iii) small- n designs ($n < 10$) and case studies, and (iv) studies of EFT for couples. These exclusion criteria were utilized to maximize the ability to describe objective quantitative findings from the included research and to focus on describing the main effects of EFT as an individual psychotherapy intervention. Because of linguistic limitations, only studies which were published in English or Spanish were reviewed. Because anxiety can be broadly defined, anxiety outcomes were included so long as they assessed general forms of anxiety (e.g., apprehensive expectation, worry, autonomic, and/or physiological arousal) were included, but specific phobic anxieties (e.g., social anxiety, agoraphobia, panic disorder) were excluded, as these fall under the fear subfactor in the HiTOP model.

Study Screening/Inclusion

Study inclusion was determined after three steps of search and screening. First, the initial search was conducted. Then, titles were screened. Titles appearing to meet inclusion criteria were selected for full-text revision. Finally, studies which met inclusion criteria were reviewed, and information from each included study was extracted. The year of publication was not limited to a specific timeframe. The first author (DDW) conducted the searches and article screening/inclusion.

Synthesis Plan and Meta-Analysis

We extracted the following pieces of data from each study: sample size, target population, pre- and post-means and *SDs*, sample demographics, and country of origin. To address aim 1, we summarized qualitatively the existing evidence and meta-analyzed effects

using Comprehensive Meta-Analysis (v4) software. We modeled all analyses under random effects. We selected Hedges' g as our index of effect size. We selected subgroup as the unit of analysis to account for studies which compared EFT to multiple control groups. We also nested outcome measures within subgroups for studies with multiple outcomes or multiple measures per outcome. We assessed publication bias using Egger's regression test, which regresses the effect sizes on the inverse of the standard error. We used Duval and Tweedie's trim-and-fill method to assess the possibility of missing studies due to publication bias. Finally, we calculated τ , I^2 , and Cochran's Q to estimate heterogeneity.

To address aim 2, we reviewed study demographic data to establish internal and external validity growth areas. Specifically, research design, control, and sample size were considered as internal validity indicators, whereas sample demographics and country of origin were considered external validity factors.

Quality Coding

Two authors who were first-year doctoral-level psychology students (DDW and MJ) independently conducted quality coding using a guide provided by the US National Institutes of Health (National Heart, Lung, and Blood Institute, 2021), with one having ongoing supervised experience in conducting/managing RCTs by the final author, as well as both students having prior experience conducting risk of bias for RCTs. Each article was quality coded using indicators of quality and bias for their respective designs. For example, RCTs were quality coded using guidance for RCTs, while noncontrolled studies were quality coded using guidance for non-controlled studies (i.e., noncontrolled studies were not compared to a strong RCT, but instead to a strong non-RCT). A final quality code designation (poor, fair, and good) was given to each study, and any discrepancies between coders were resolved through discussion to reach a consensus. Initial agreement was strong (85%), suggesting good interrater reliability. Additionally, we conducted the Risk of Bias for RCTs using Cochrane's Risk of Bias 2 (ROB-2) tool (Sterne et al., 2019). ROB-2 assesses the risk of bias across five domains: randomization (Domain 1), deviation from the intended intervention (Domain 2), missing outcome data (Domain 3), measurement of the outcome (Domain 4), and selection of the reported result (Domain 5). Similarly, ROB-2s were conducted independently by raters with prior experience conducting ROB. Though ROB-2 automates a risk of bias rating based on selected responses to questions, the

ratings in the current study were finalized via consensus between raters.

Results

The search yielded a total of 2386 results, 919 of which were identified as duplicates. As such, 1467 unique study titles were screened, of which 1445 were excluded after title screening. Twenty-two full texts were reviewed, and 13 were included in the current systematic review. The PRISMA flow chart for the search and screening process can be found in Figure 1. Of the 13 articles which met inclusion criteria ($n = 348$ participants receiving EFT, of which 204 were assigned to receive EFT in controlled trials; and 201 were assigned to control groups), 11 examined depressive symptoms as an outcome, 6 explored anxiety as an outcome, and 3 examined PTSD symptoms as an outcome. No articles which examined EFT for BPD were found. Study intervention characteristics and outcomes can be found in Table I. Study characteristics such as where the study was conducted and sample demographics, as well as quality code, can be found in Table II. ROB-2 ratings can be found in Table III.

Primary Analyses

Depression

EFT compared to inactive controls. Five articles (Amirshahi et al., 2024; Bardezard et al., 2021; Dehnavi et al., 2024; Khanjani & Mousavi Asl, 2021; Salarirad et al., 2022; Zadaafshar et al., 2021) examined EFT compared to inactive controls (e.g., waitlist/placebo). Two of these (Amirshahi et al., 2024; Zadaafshar et al., 2021) compared EFT to both an inactive and an active control, and we therefore discuss these in the following section. Bardezard et al. (2021) conducted a randomized controlled trial (RCT) of 10 sessions of EFT versus placebo (nutritional counseling) in a sample of Iranian females with binge eating disorder (BED; $n = 20$ in each group). They found that EFT resulted in significant decreases in depressive symptoms. Dehnavi et al. (2024) examined a RCT of 16 sessions of EFT versus WLC ($n = 24$ in each group) in a sample of Iranian females with premenstrual dysphoric disorder (PMDD). They found that only the EFT group experienced significant decreases in depressive and PMDD symptoms from pre- to post-treatment. Finally, Salarirad et al. (2022) examined the effect of EFT on depressive symptoms in Iranian females with breast cancer in a RCT compared to WLC ($n = 15$ in each group). They found that EFT resulted

in significant decreases in depressive symptoms compared to the WLC.

EFT compared to active controls. Six articles compared EFT to active control (Amirshahi et al., 2024; Goldman et al., 2006; Paivio et al., 2010; Timulak et al., 2022; Watson et al., 2003; Zadaafshar et al., 2021). Amirshahi et al. (2024) examined the effect of 11 sessions of EFT on depressive symptoms in Iranian females with polycystic ovarian syndrome (PCOS). The authors conducted an RCT comparing EFT to a waitlist control (WLC) and cognitive-behavioral therapy (CBT; $n = 15$ in each group). The authors found significant effects of the interventions on depressive symptoms, with CBT evidencing a slightly larger (though not significantly different) effect than EFT. In a sample of patients with MDD, Goldman et al. (2006) conducted an RCT comparing EFT to person-centered therapy ($n = 19$ in each group). They found that, while both groups saw decreases, EFT resulted in larger decreases in depressive symptoms across treatment. Paivio et al. (2010) examined two versions of EFT in an RCT with a sample of adult survivors of child abuse ($n = 45$ total). They found that both versions of EFT were similarly effective for reducing depression. In Irish patients with GAD, Timulak et al. (2022) examined EFT versus CBT and found that both treatments resulted in significant decreases in depressive symptoms, with CBT showing similar but slightly larger effects. Watson et al. (2003) compared EFT to CBT in an RCT of patients with MDD ($n = 45$ in the EFT group, 40 in the CBT group). They found that both groups experienced significant decreases in depressive symptoms, with no significant differences between the two interventions. Finally, Zadaafshar et al. (2021) conducted an RCT of group EFT compared to an existential therapy group and a WLC ($n = 15$ in each group). They found that both treatment groups experienced significant decreases in depressive symptoms compared to the WLC, with no significant differences between the treatment groups.

Noncontrolled EFT studies. Two studies examined pre-post single-arm trials of EFT without control groups. Kramer et al. (2026) examined EFT in a naturalistic pre-post single-arm study with general psychiatry patients in Switzerland and Germany ($n = 70$). They found that patients experienced significant decreases in depressive symptoms from pre- to post-treatment, but the lack of a control group precluded strong conclusions regarding the exact nature of the intervention's effect. Timulak et al. (2017) examined EFT in a sample

PRISMA Flow Chart for Inclusion of Studies

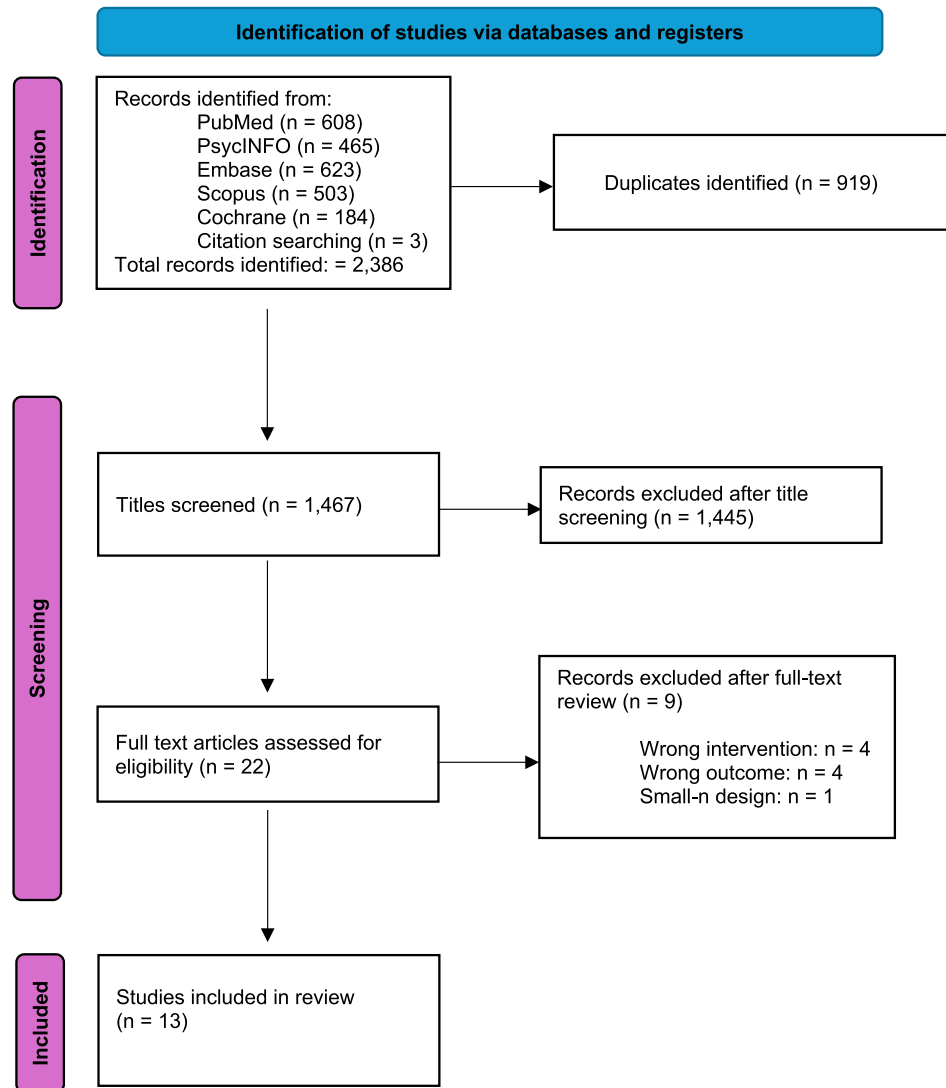


Figure 1. PRISMA flow chart for inclusion of studies.

of patients with GAD ($n = 14$) and found that the sample experienced significant decreases in depressive symptoms from pre- to post-treatment. Likewise, the lack of a control group precludes true causal conclusions.

Anxiety. Seven studies (Amirshahi et al., 2024; Bardezard et al., 2021; Dehnavi et al., 2024; O’Connell Kent et al., 2021; Timulak et al., 2017, 2022; Zadafarshar et al., 2021) assessed anxiety as an outcome. Three studies (O’Connell Kent et al., 2021; Timulak et al., 2022) specifically assessed EFT for patients diagnosed with GAD or who indicated anxiety as a primary presenting concern. For a review of the methodology of all studies except

O’Connell Kent et al. (2021), please refer to [Table I](#) or the prior section regarding depression outcomes, as all anxiety measures were derived from these same studies. All studies except one (Dehnavi et al., 2024) found that EFT resulted in significant decreases in anxiety. Additionally, all studies except one (O’Connell Kent et al., 2021) conducted RCTs.

As stated previously, Amirshahi et al. (2024) examined EFT in females with PCOS compared to WLC and CBT and found that the treatment groups experienced significant decreases in anxiety from pre- to post-treatment. Bardezard et al. (2021) found in females with BED that EFT resulted in significant decreases in anxiety from pre- to post-treatment. Dehnavi et al. (2024) found that EFT did not significantly alter anxiety symptoms in

Table I. Study treatment design characteristics and outcomes.

Study	Target group	Research design	Control	N _{tx}	N _{ctr}	N _{ses}	Tx Type	Outcome	Results
Amirshahi et al. (2024)	Females with PCOS	RCT	WLC and CBT	15	15	11	Ind	Depression Anxiety	Both groups experienced significant decreases in depression symptoms, with CBT showing larger effects
Bardezard et al. (2021)	Females with BED	RCT	Placebo/ Nutrition counseling WLC	20	20	10	Ind	Depression Anxiety	EFT resulted in significant decreases in depression and anxiety. It is unclear to what extent the control group experienced changes
Dehnavi et al. (2024)	Females with PMDD	RCT	WLC	24	24	16	Ind	PMDD sx Depression Anxiety	Only the tx group experienced significant decreases in PMDD and depression across treatment, but there were nonsignificant changes in anxiety
Goldman et al. (2006)	Patients with MDD	RCT	PCT	19	19	17.5	Ind	Depression	Both groups experienced significant decreases in depression, with EFT showing larger effects
Kramer et al. (2026)	General psychiatry patients	Naturalistic pre-post single arm	–	70	–	–	Ind	Depression	EFT resulted in significant decreases in depression from pre- to post-tx
O'Connell Kent et al. (2021)	College students with primary anxiety concern	Pre-post single arm	–	15	–	8	Ind	Anxiety	EFT resulted in significant decreases in anxiety from pre- to post-tx. However, qualitative data revealed that history effects may have influenced these results
Paivio et al. (2010)	Adult survivors of child abuse	RCT	Alternative form of EFT ^a	45	–	–	Ind	PTSD sx Depression	Each format of EFT resulted in significant decreases in PTSD sx severity and depression from pre- to post-tx
Paivio and Nieuwenhuis (2001)	Adult survivors of child abuse	RCT	WLC	22	24	19.2	Ind	Trauma	EFT resulted in significant decreases in PTSD symptoms compared to control
Salarirad et al. (2022)	Females with breast cancer	RCT	WLC	15	15	12	Ind	Depression	EFT resulted in significant decreases in depression compared to control
Timulak et al. (2022)	Patients with GAD	RCT	CBT	29	29	16.69	Ind	Depression Anxiety	Both groups experienced significant decreases in depression and anxiety, with no significant differences
Timulak et al. (2017)	Patients with GAD	Pre-post single arm	NA	14	–	19.35	Ind	Depression Anxiety	EFT resulted in significant decreases in depression and anxiety from pre- to post-treatment
Watson et al. (2003)	Patients with MDD	RCT	CBT	45	40	15	Ind	Depression	Both groups experienced significant decreases in depression, with no significant differences between the groups
Zadafshar et al. (2021)	Adult victims of child sexual harassment	RCT	Existential Group/WLC	15	15	9	Group	Depression Anxiety	Both tx groups experienced significant decreases in depression and anxiety compared to control, with no significant differences between the groups

Note. BED = binge eating disorder. CAD = coronary artery disease. PMDD = premenstrual dysphoric disorder; MDD = major depressive disorder; RCT = randomized controlled trial; WLC = waitlist control; PCT = person-centered therapy; GAD-7 = generalized anxiety disorder-7 screener; GADSS = generalized anxiety disorder severity scale; sx = symptoms; tx = treatment; N_{tx} = sample size of treatment group; N_{ctr} = sample size of control group; N_{ses} = number of sessions.

Table II. Study sample demographics and quality coding.

Study	Percent female	Mean age intervention (<i>SD</i>)	Mean age control (<i>SD</i>)	Patient population	Ethnic breakdown	Country from which study originates	Funding	Quality coding
Amirshahi et al. (2024)	100%	25–45 ^a	25–45 ^a	Females with PCOS	100% Iranian	Iran	None	Poor
Bardezdard et al. (2021)	100%	38.4 (11.6)	39.56 (7.58)	Females with BED	100% Iranian	Iran	None	Poor
Dehnavi et al. (2024)	100%	29.33 (5.44)	31.58 (4.86)	Females with PMDD	100% Iranian	Iran	None	Fair
Goldman et al. (2006)	64%	39.5 (9.71)		Patients with MDD	89% White	Canada/USA	OMHF/ NIMH	Poor
Kramer et al. (2026)	56%	37.5 (12.08)	–	Patients with MDD, anxiety, PTSD, or interpersonal issues	Unknown	Switzerland/Germany	AEMD	Poor
O’Connell Kent et al. (2021)	80%	22.73 (2.94)	–	College Students	Unknown	Ireland	None reported	Poor
Paivio et al. (2010)	53%	45.64 (12.99)	45.70 (14.96)	Adults with a history of childhood maltreatment	89% White	Canada	OMHF	Poor
Paivio and Nieuwenhuis (2001)	85%	36.86 (11.61)	36.25 (12.44)	Adults with history of childhood abuse	91% White	Canada	SSHRC	Fair
Salarirad et al. (2022)	100%	45.6 (8.11)	43.4 (6.94)	Females with breast cancer	100% Iranian	Iran	None reported	Poor
Timulak et al. (2022)	84%	37.1 (11.09)	32.9 (10.6)	Patients with GAD	97% White	Ireland	HRB	Poor
Timulak et al. (2017)	86%	35.5 (8.98)	–	Patients with GAD	Unknown	Ireland	HRB	Fair
Watson et al. (2003)	67%	41.52 (10.82)	37.33 (12.79)	Patients with MDD	91% White	Canada	SSHRC	Fair
Zadafshar et al. (2021)	76%	25.26 (4.12)	25.46/25.53 (3.65/4.72)	Adults with a history of childhood sexual harassment	100% Iranian	Iran	None	Fair

Not. ^a A precise average not provided; estimates based on inclusion. PCOS = polycystic ovarian syndrome; binge eating disorder; PMDD = premenstrual dysphoric disorder; MDD = major depressive disorder; OMHF = Ontario Mental Health Foundation/National Institute of Mental Health. AEMD appears to be a charity organization which funds healthcare research in Switzerland; researchers were unable to find more precise details. SSHRC = Social Sciences and Humanities Research Council of Canada. GAD = generalized anxiety disorder. HRB = Health Research Board.

Table III. Risk of bias for randomized trials.

Study	Domain 1	Domain 2	Domain 3	Domain 4	Domain 5	Overall rating
Amirshahi et al. (2024)	High	Low	High	Low	Some concerns	High
Bardezard et al. (2021)	High	Low	High	Low	Some concerns	High
Dehnavi et al. (2024)	Low	Low	Low	Low	Low	Low
Goldman et al. (2006)	Low	Low	Some concerns	Low	Some concerns	Some concerns
Paivio et al. (2010)	High	Low	High	Low	Low	High
Salarirad et al. (2022)	High	Low	High	Low	Some concerns	High
Timulak et al. (2022)	Some concerns	Low	Low	Low	Low	Some concerns
Watson et al. (2003)	Some concerns	Low	Some concerns	Low	Low	Some concerns
Zadafshar et al. (2021)	Some concerns	Low	Some concerns	Low	Low	Some concerns

women with PMDD. O'Connell Kent et al. (2021) found that college students who underwent eight sessions of EFT experienced significant decreases in anxiety from pre- to post-treatment. However, they gathered qualitative data where several participants noted decreases in external stressors during the course of treatment, which are likely confounded with treatment effects. Timulak et al. (2022) found in a sample of patients with GAD that EFT resulted in significant decreases in anxiety levels, though CBT slightly (but not significantly) outperformed EFT in anxiety reduction. Timulak et al. (2017) also examined the effects of EFT in a single-arm trial in a small sample of patients with GAD and found that individuals experienced significant decreases in anxiety. Finally, Zadafshar et al. (2021) examined group-based EFT versus WLC and existential group. They found that both intervention groups experienced significant decreases in anxiety compared to the WLC group, with no significant differences between the two groups.

Posttraumatic stress. Only two studies (Paivio et al., 2010; Paivio & Nieuwenhuis, 2001) examined EFT for treating posttraumatic stress disorder (PTSD) symptoms. As mentioned previously, Paivio et al. (2010) conducted an RCT of two forms of EFT (total $n = 45$). They found that participants experienced significant decreases in PTSD symptoms from pre- to post-treatment, with no significant differences between the two conditions. Similarly, Paivio and Nieuwenhuis (2001) conducted a quasi-experimental study of EFT ($n = 22$) versus WLC ($n = 24$) in a sample of adult survivors of child abuse. They found that EFT resulted in significant decreases in PTSD symptoms compared to the WLC.

Meta-Analysis of Findings

We conducted a random effects meta-analysis of *controlled* studies where enough information was

available to conduct such analysis ($n = 8$ studies, excluding Bardezard et al. (2021) due to missing data and Paivio et al. (2010) due to comparing two versions of EFT). Additionally, Dehnavi et al. (2024) did not provide post-test *SDs*, and we failed to retrieve this information after attempting to contact the corresponding author. As such, we utilized pre-test *SDs* for the analysis. Relatedly, they reported the *SD* of the baseline Depression, Anxiety, and Stress-21 Scale mean as 80.30, which is statistically impossible. We were again unable to retrieve the correct estimate, and therefore, we assumed the intended estimate to be 8.30 and used this in our analysis.

We found some evidence of publication bias, with slight funnel plot asymmetry (see Figure 2) and a significant Egger's test (intercept = 8.89, $p = .01$). The results were highly heterogeneous, $\tau = 0.74$, $Q(7) = 44.66$, $p < .001$, $I^2 = 84\%$. Overall, results favored EFT over control conditions ($k = 8$ studies; $g = .86$, $SE = .25$, 95% CI = [.37, 1.34]). The forest plot detailing study effects compared to control at the study subgroup level can be found in Figure 3. This effect was stronger for inactive controls (i.e., waitlists; $g = 1.39$, $SE = .17$, 95% CI = [1.06, 1.72]) than active controls (i.e., other psychotherapies; $g = .28$, $SE = .24$, 95% CI = [−.19, .76]).

Findings from Study Demographics and Quality Coding

In addition to findings related to the intervention, there were notable findings related to the demographic makeup of the existing studies (see Table II). Four of the 13 studies included only females (Amirshahi et al., 2024; Bardezard et al., 2021; Dehnavi et al., 2024; Salarirad et al., 2022; Zadafshar et al., 2021), with an additional five studies having samples comprised of >70% females (O'Connell Kent et al., 2021; Paivio & Nieuwenhuis, 2001; Timulak et al., 2017, 2022; Zadafshar et al., 2021).

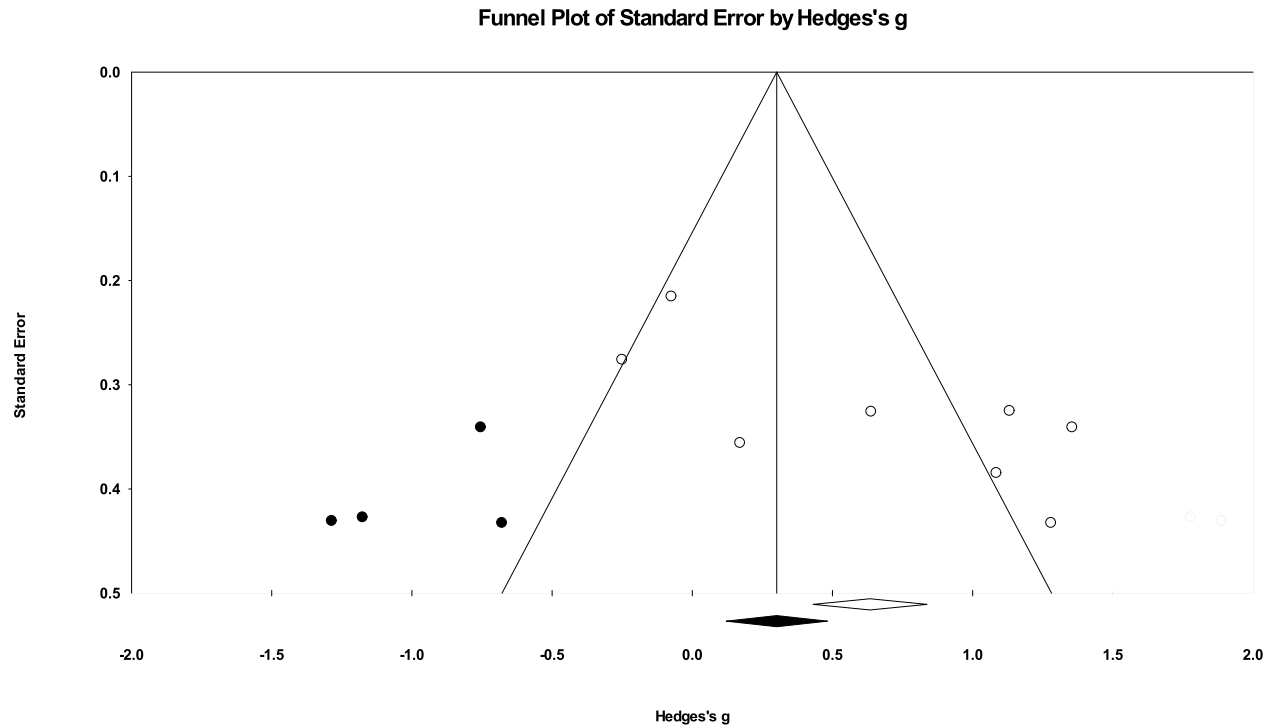


Figure 2. Funnel plot of publication bias of published randomized controlled trials. *Note.* Shaded circles represent imputed studies.

Five studies were also conducted with Iranian individuals (Amirshahi et al., 2024; Bardezard et al., 2021; Dehnavi et al., 2024; Salarirad et al., 2022). Another three had samples comprised of >70% White participants (Goldman et al., 2006; Paivio et al., 2010; Timulak et al., 2022). We were unable to locate studies conducted with Asian, Hispanic, or African persons. All studies were conducted in North America, Europe, and Iran. Nearly all studies were also conducted with adults in mid-established adulthood (e.g., mid 30s to early 40s on

average), with only one having a primarily young adult-aged sample, and none having been conducted with older adults. We also found that the existing literature suffers from a variety of methodological concerns. Most studies had large drop-out rates, failed to use intention-to-treat analyses, and/or lacked adequate randomization procedures. Most (62%) of the studies were rated as having “poor” methodological quality, and none were rated as having “good” quality. In the ROB findings, most RCTs suffered from randomization concerns (e.g., failure to

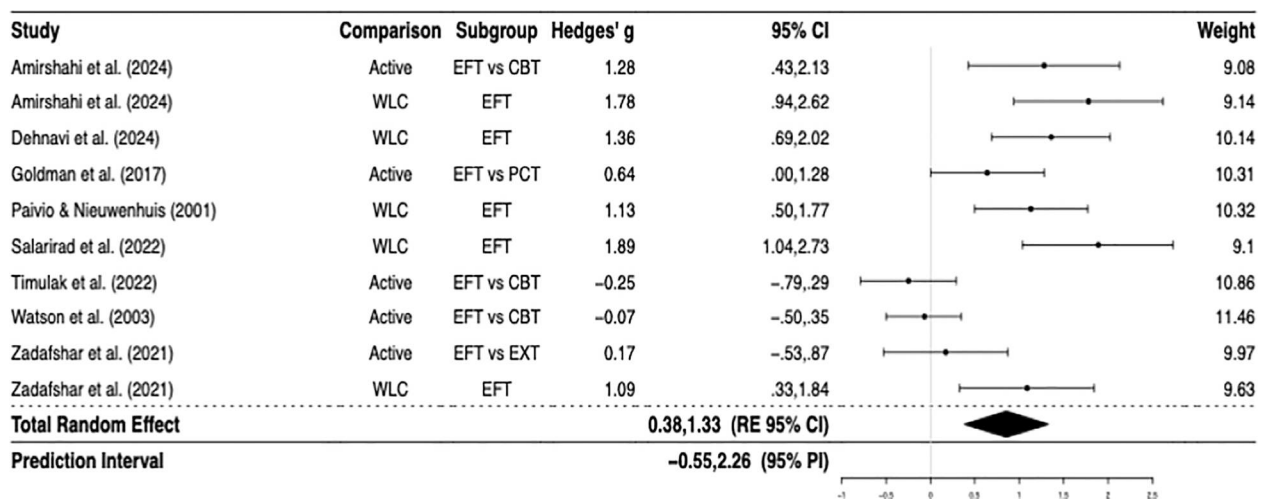


Figure 3. Forest plot of effects for studies with control conditions.

adequately describe randomization, baseline differences between groups) and missing outcome data (i.e., failure to use intention-to-treat, large drop-out rates, failure to discuss attrition).

Discussion

The current systematic review and meta-analysis evaluated the existing evidence for using EFT to treat internalizing distress-based psychopathology, including depression, generalized anxiety, PTSD, and BPD. Of 13 studies which met inclusion criteria, nearly all assessed or targeted depressive symptoms, around half examined anxiety as an outcome, and only two studies assessed EFT for PTSD. All studies found significant effects of EFT on depressive symptoms, six of seven studies found significant effects on anxiety, and both studies which assessed PTSD found significant effects. Meta-analysis of existing controlled studies found that EFT outperformed waitlist controls but not other psychotherapies, and there was moderate evidence for publication bias. Moreover, all studies were conducted in Iran, Europe, or North America, with a vast majority of the research having been on White individuals and females.

Studies on Depression

In line with current recommendations (Stiegler et al., 2018), we found evidence of effectiveness for using EFT for depression. Existing evidence suggests that EFT is effective for treating depressive symptoms. The existing evidence also suggests that EFT can effectively treat depressive symptoms in a variety of clinical populations (e.g., PTSD populations, eating disorder populations, specific medical populations, populations with a primary anxiety concern). As such, the current meta-analytic evidence suggests that EFT effectively targets depressive symptoms as both a primary and secondary outcome with similar effects.

Though the existing evidence supports the use of EFT for treating depression, the research in this area suffers from various sources of bias. There are several RCTs examining EFT for depression, but existing research has been mostly conducted on all quite small samples ($n < 30$ per group). Additionally, existing evidence suggests comparable effects to current recommended treatments, primarily CBT, with CBT potentially evidencing slightly larger effects. As such, whether EFT can be more effective than existing treatments has not yet been fully explored. At best, EFT may be equally effective as existing treatments such as CBT (Amirshahi et al.,

2024; Timulak et al., 2022). However, the evidence does not support EFT's incremental effectiveness over existing treatments. Future research should continue to explore the incremental effectiveness of EFT over other forms of psychotherapy for primary outcomes. Finally, existing research has been largely conducted in Iranian and White females. As such, it is largely unclear to what extent EFT is effective for treating depression in more diverse populations (e.g., racially/ethnically diverse, gender diverse, LGBTQ populations).

Generalized Anxiety

Similar to depression, the evidence appears to support the use of EFT for treating general forms of anxiety. However, unlike depression, the effects of EFT on anxiety as a secondary outcome may be less apparent. In a study of EFT for patients with PMDD (Dehnavi et al., 2024), where anxiety was a secondary outcome, the authors did not find that EFT resulted in decreases in anxiety. However, the evidence of EFT for individuals with primary anxiety concerns seems to be more promising. EFT demonstrates significant effects on anxiety in patients with GAD or primary anxiety concerns. This supports psychotherapists' use of EFT with patients suffering from primary anxiety concerns.

The quality concerns for studies on anxiety are similar to those of depression, given that many studies assessed the outcomes simultaneously. Additionally, the populations where anxiety was a primary concern (O'Connell Kent et al., 2021; Timulak et al., 2017, 2022) are more demographically homogeneous. This limits the ability to describe how effective EFT is for treating anxiety in more diverse populations.

The current evidence examining EFT in relation to existing evidence-based interventions for anxiety is also limited. Due to only a small number of studies existing for anxiety, we were unable to assess the effects of interventions compared to specific controls (e.g., waitlist versus active controls). As such, our meta-analysis does not provide much evidence regarding whether EFT for anxiety outperforms other psychotherapies. Currently, CBT is the recommended treatment of choice for GAD and has accumulated a large body of evidence (Papola et al., 2024). More research is needed to better understand if and what incremental benefits EFT can provide over existing psychotherapies. For instance, can EFT provide theory-specific incremental benefits (e.g., increase emotion awareness/acceptance) above and beyond those produced by existing psychotherapies? Future researchers may consider

examining whether EFT can produce these differential effects.

Posttraumatic Stress Disorder

Only two studies assessed EFT for PTSD symptoms, though existing evidence holds promise. PTSD involves negative emotionality and alterations in beliefs about oneself and others. As such, EFT may hold much promise for use with patients with PTSD. However, the little existing evidence is becoming outdated, and therefore, more current research with more diverse populations is needed to better elucidate how effective EFT can be for PTSD. Additionally, the existing research has focused on specific forms of trauma (e.g., child abuse/neglect, Paivio et al., 2010; Paivio & Nieuwenhuis, 2001). Little is known about the use of EFT with other forms of traumatic experiences. Finally, we were only able to assess PTSD symptoms in the context of an omnibus analysis, which does not allow for generating specific estimates of EFT's effectiveness. As such, future researchers should prioritize additional trials for PTSD and examining EFT for diverse forms of trauma.

Overall, our systematic review and meta-analysis find that EFT demonstrates promise for patients presenting with distress-based dysfunction. Though we did not find any published EFT trials for BPD, we believe that it is likely that EFT will demonstrate effectiveness given BPD's shared features (e.g., dysphoria, anxious worry) with other forms of distress-based psychopathology. In the current study, we found that EFT is moderately effective for presenting concerns that share features such as anxious worry, dysphoria, and pervasive negative emotionality. Emerging evidence points toward EFT broadly being effective for internalizing psychopathology, given prior evidence of its effectiveness for eating pathology (Osoro et al., 2022) as well. From a HiTOP perspective, future research will be needed on fear-based psychopathology (e.g., phobias) and sexual problems (e.g., sexual pain disorders) to determine EFT's effectiveness across internalization problems.

We also demonstrate how the HiTOP provides a guiding framework for organizing clinical trial outcome research. Whereas the DSM arbitrarily defines diagnoses on the basis of superficial characteristics (e.g., the obsessive-compulsive and related disorders group), the HiTOP attempts to organize psychopathology on the basis of observed symptom covariation (Kotov et al., 2022). This approach provides researchers with an empirically derived framework for increasing trial inclusivity. For example,

GAD and MDD generally share symptom overlap (Ringwald et al., 2021), and from a HiTOP perspective, fall under the same spectra (distress-based dysfunction). This is possibly because of shared underlying etiological factors. As such, both should respond to treatment similarly, which is what we observed for EFT. Accordingly, and in-line with broader humanistic theory, we believe that this is an argument to move away from DSM-based diagnoses. Similar arguments are currently being made for acceptance and commitment therapy, where it has been observed that significant portions of prospective clinical trial applicants are turned away from treatment for not meeting strict DSM criteria (Borgogna & Aita, 2025). We suggest more theoretically inclusive inclusion criteria for clinical trials, such as distress-based dysfunction (or even broader such as internalization), as it provides a framework for clinical trial research that will reach more people and lead to improved intervention.

Findings Related to Methodological Quality of Studies

The current review provides clear evidence that the EFT research suffers from various methodological problems. In addition to modest evidence for missing studies and publication bias, most studies failed to use intention-to-treat (ITT) analyses, had small samples with large drop-out rates, or failed to discuss drop-out rates at all. Failure to use ITT analyses likely biases effect size estimates upwards. ITT analyses model all original participants as originally randomized under the assumption that excluding individuals for reasons such as nonadherence to the protocol or intervention biases the effect sizes, as it creates an unrealistic view of the intervention's true effects (Gupta, 2011; McCoy, 2017). As such, particularly when dropout is known to be related to factors such as increased symptom severity or dissatisfaction with the treatment, failing to use ITT creates a more desirable view of the intervention effectiveness than exists. These factors suggest that the current estimates of EFT's effectiveness are likely biased upward and that the true effectiveness of EFT is less than what evidence might suggest. Future researchers should aim to use statistical approaches that lead to the most precise estimates (e.g., intention-to-treat analyses) when available.

We also found significant concerns with randomization procedures in published trials. Many trials failed to adequately describe their randomization process or failed to use concealed allocation sequences, given that concealed allocation prevents bias in the randomization process, as the individual

randomizing participants is therefore unable to influence any participant's assignment to groups. True randomization maximizes internal validity and confidence in conclusions regarding an intervention's ability to cause improvements in the outcome. As Vorland et al. (2021) point out, some researchers describe trials as "randomized" without utilizing true random allocation, rendering the studies quasi-experimental. However, without any description of randomization procedures beyond stating simply that participants were randomly allocated to conditions, readers are left unsure of whether true randomization occurs. This can and perhaps should erode trust in conclusions derived from such studies.

A final major methodological concern we found with the existing EFT literature is consistent employment of underpowered studies. Most (53%) studies used sample sizes of ≤ 20 participants per group. Such studies are immensely underpowered to detect many between-group differences. This is particularly concerning when attempting to compare EFT to an active control rather than a waitlist. Additionally, and relatedly, small sample sizes demonstrate increased variation and error, decreasing statistical power and increasing uncertainty in the effect size estimate. We encourage future researchers to focus on conducting well-designed and adequately powered studies to assess the true nature of EFT's effectiveness. We contend that fewer well-designed trials show stronger evidence than more poorly designed studies.

Limitations and Future Directions

As previously identified, the existing research provides preliminary evidence for the effectiveness of EFT for depression, generalized anxiety, and post-traumatic stress. Though conceptual research on using EFT to treat BPD exists (Pos & Greenberg, 2012), the current systematic review did not find any empirical evidence for using EFT to treat BPD. However, given that BPD involves pervasive emotional dysregulation (Chapman, 2019), it would seem that EFT could be a relevant treatment option and offer promise. Additionally, most of the existing research has been conducted on females and largely White populations. Given that some populations (e.g., men or individuals from diverse cultural backgrounds; Bryde Christensen et al., 2023; Hutchison & Gerstein, 2017) may be less socialized or open to working with emotions directly, EFT may need to be culturally adapted for specific populations to maximize effectiveness. Additionally, EFT is guided but largely nondirective. As some populations may also be more likely to prefer more

directive interventions (e.g., Asian populations; Pan et al., 2019), EFT may also need to be adapted for these populations. Additionally, much existing EFT research has been conducted by a select few authors with notable allegiances to EFT. As such, a broader range of labs with fewer ties, financial or otherwise, to EFT should continue to assess the effectiveness of EFT to reduce bias in the evidence. Finally, the existing evidence for using EFT for any of the current presenting concerns is primarily of low quality, leaving the true effect of EFT on such outcomes unknown. Further methodologically rigorous research is needed to evaluate EFT's effectiveness.

Conclusion

In line with current recommendations, the current systematic review and meta-analysis provides evidence for the effectiveness of EFT for some elements of internalizing distress-based psychopathology, primarily for depressive symptoms. Modest evidence also exists for treating anxiety (anxious worry and autonomic arousal more specifically) with EFT, though research on GAD-specific samples or using GAD-specific measures is minimal. Finally, little evidence exists for using EFT for treating posttraumatic stress, though existing evidence shows promise. Additionally, existing evidence suggests that EFT is equally effective to other psychotherapies, with no evidence for incremental effectiveness. Finally, we found that most existing EFT research in this area has been conducted with White and female populations, though research with mixed gender samples has also shown effectiveness. Overall, EFT appears to be a promising intervention for use with distress-based psychopathology.

Disclosure Statement

No potential conflict of interest was reported by the author(s).

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