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Comparing the Effectiveness of Emotion-Focused Therapy (EFT) and Cognitive-Behavioral Couple Therapy (CBT) in Reducing Anxiety, Depression, and Improving Relationship Quality Among Couples with Childhood Trauma

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A B S T R A C T

Objective: The objective of this study was to compare the effectiveness of Emotion-Focused Therapy (EFT) and Cognitive-Behavioral Couple Therapy (CBT) in reducing anxiety, depression, and enhancing relationship quality in couples with a history of childhood trauma.
Methods and Materials: This randomized controlled trial included 45 couples (90 individuals) recruited from counseling centers in Tehran and Karaj, of whom 15 couples were assigned to EFT, 15 to CBT, and 15 to a no-treatment control group. Eligibility criteria required being married for at least two years and having at least one partner with documented childhood trauma. The interventions consisted of 8–12 weekly 60–90-minute sessions delivered by trained therapists. Standardized instruments—the Beck Anxiety Inventory (BAI), Beck Depression Inventory-II (BDI-II), and Dyadic Adjustment Scale (DAS)—were administered at pretest, posttest, and a three-month follow-up. Data were analyzed using repeated-measures ANOVA and Bonferroni post-hoc tests in SPSS-27 to examine intervention effectiveness and between-group differences.
Findings: Repeated-measures ANOVA showed significant main effects of time, group, and time × group interactions for anxiety ($F = 112.38$, $p < .001$, $\eta^2 = .79$), depression ($F = 118.57$, $p < .001$, $\eta^2 = .81$), and relationship quality ($F = 129.74$, $p < .001$, $\eta^2 = .82$). Bonferroni post-hoc tests indicated that both EFT and CBT produced statistically significant improvements from pretest to posttest and from posttest to follow-up for all outcomes (all $p < .05$), whereas the control group showed no significant changes. Between-group comparisons revealed that EFT produced significantly greater improvements than CBT in anxiety ($p = .031$), depression ($p = .028$), and relationship quality ($p = .017$), and both interventions outperformed the control group across all variables (all $p < .001$).
Conclusion: The findings demonstrate that both Emotion-Focused Therapy and Cognitive-Behavioral Couple Therapy are effective in reducing anxiety and depression and enhancing relationship quality in couples with childhood trauma, with EFT showing consistently stronger and more sustained effects across emotional and relational dimensions.
Keywords: *Emotion-Focused Therapy; Cognitive-Behavioral Couple Therapy; Childhood Trauma; Anxiety; Depression; Relationship Quality*

1. Introduction

Childhood trauma is among the strongest developmental predictors of emotional dysregulation, psychopathology, and relational impairment in adulthood. Couples in which one or both partners have experienced adverse childhood events often face greater vulnerability to anxiety, depression, interpersonal insecurity, and chronic conflict, all of which erode relationship quality and increase the likelihood of maladaptive marital patterns (Mair et al., 2012). Empirical models show that childhood trauma disrupts attachment systems, undermines emotion regulation, and shapes negative cognitive schemas, making adult romantic relationships especially susceptible to distress and maladaptive coping (Sharif Nia et al., 2023). These difficulties tend to manifest in heightened reactivity, distrust, emotional withdrawal, and difficulties with intimacy, which collectively hinder the development of secure relational bonds. Research in clinical and community samples further confirms that early adversities contribute to a cascade of relational vulnerabilities such as dysfunctional communication, lower marital satisfaction, and increased conflict escalation (Kiani Chalmardi et al., 2022). Given the profound impact of childhood trauma on adult relational functioning, identifying effective therapeutic approaches for these couples remains a clinical priority.

Within couple therapy research, Emotion-Focused Therapy (EFT) has gained substantial empirical attention as a treatment modality rooted in attachment theory and emotion science. EFT conceptualizes relationship distress as emerging from negative interactional cycles, in which unmet attachment needs and primary emotional experiences remain unrecognized or unexpressed (Greenman & Johnson, 2022). EFT therapists help partners access and express vulnerable emotions, restructure negative cycles, and create secure bonding interactions that promote emotional accessibility and responsiveness (Timulak et al., 2025). This approach is particularly relevant for couples with trauma histories, as trauma often results in emotional numbing, avoidance, hypervigilance, and difficulty engaging in secure relational behaviors. Foundational clinical evidence shows that EFT reduces depressive symptoms, enhances intimacy, and improves emotional functioning among trauma-exposed couples, even in cases involving severe attachment injuries (MacIntosh & Johnson, 2008). More recent studies in Iranian and international contexts confirm the significant impact of EFT on relationship quality, marital burnout, emotional regulation, and psychological well-being (Bahrami Moqadam et al., 2023; Moqadam, 2023; Raghieh Parham, 2022). Likewise, contemporary EFT research highlights its transdiagnostic applications, demonstrating symptom reduction across anxiety, depression, mood instability, and relational disturbances, making it especially suitable for couples with complex trauma-related presentations (Timulak et al., 2025).

Studies focusing specifically on Iranian couples also show strong outcomes for EFT. For example, EFT has been reported to improve marital happiness and quality of life in dual-income couples (Roghayeh Parham, 2022), reduce depression and marital burnout in distressed couples (Moqadam, 2023), and enhance relationship quality and emotional regulation (Parsa Najad, 2024). Similarly, integrating EFT with compassion-based approaches has proven beneficial in improving marital quality of life and addressing attachment dimensions among couples experiencing relational strain (Khajeh et al., 2022). These studies underscore EFT's cultural adaptability and effectiveness in contexts similar to the current research setting.

In contrast, Cognitive-Behavioral Couple Therapy (CBT) is grounded in cognitive restructuring, behavioral interventions, and communication skills training. CBT emphasizes modifying maladaptive thoughts, enhancing adaptive behaviors, and reducing conflict through structured problem-solving skills. Substantial research has supported CBT's effectiveness for couples with anxiety, depression, or relational dysfunction. For example, Durães and colleagues demonstrated that CBT reduces depressive and anxiety symptoms and improves dyadic adjustment and social skills among couples facing significant relational distress (Durães et al., 2020). Cognitive-behavioral stress inoculation training has similarly been shown to enhance coping skills and quality of life in marital discord couples (Neda Ghasemi et al., 2022), while CBT-based sexual therapy improved sexual functioning and marital relationship quality among women experiencing sexual arousal disorders (Nezamoddin Ghasemi et al., 2022). Additional evidence from marital conflict studies demonstrates that CBT significantly improves psychological hardiness, relationship quality, and marital satisfaction (Forouzani et al., 2024). In cases involving betrayal or infidelity, CBT has also been found effective in reducing marital depression and enhancing intimacy and communication (Pajari et al., 2021).

CBT appears particularly beneficial for couples with trauma histories, given its structured approach to addressing maladaptive beliefs, trauma-related triggers, and cognitive

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distortions. For example, cognitive-behavioral interventions have significantly reduced anxiety and improved marital satisfaction in couples referred for psychotherapy in counseling centers (Rahimi et al., 2022). Additionally, CBT and behavioral marital therapy have been shown to improve marital adjustment among couples with anxiety disorders (Kavitha et al., 2024). The evidence base consistently demonstrates CBT's capacity to enhance behavioral functioning, reduce emotional symptoms, and modify dysfunctional interaction patterns—mechanisms that are essential for trauma-exposed couples.

Despite the extensive literature supporting both EFT and CBT, relatively few studies have directly compared the two approaches in populations with childhood trauma. This gap is notable because trauma-exposed couples often display unique relational dynamics that may respond differently to emotion-focused versus cognitive-behavioral interventions. Comparative research has begun to emerge, though findings are mixed. Some studies indicate that EFT may better address emotional bonding, attachment injuries, and intimacy processes (Kashtmand & Parandin, 2023), while others emphasize CBT's effectiveness in structured symptom reduction and enhancing resilience and coping mechanisms (Ammari et al., 2023). Studies comparing EFT to other modalities, such as the Gottman model, show EFT's advantages in reducing depression and improving sexual satisfaction among infertile couples (Fathi et al., 2023). Meanwhile, research comparing CBT with acceptance and commitment approaches highlights the cognitive-behavioral pathway as particularly effective for decreasing anxiety and improving marital quality (Shahbazfar et al., 2021). Though promising, these findings indicate that treatment responsiveness may be influenced by specific trauma characteristics, attachment patterns, and cognitive vulnerabilities.

The need for comparative research is further supported by findings that emotion-focused and problem-focused dyadic coping strategies differentially benefit anxiously versus avoidantly attached partners (Vedelago et al., 2023). This suggests that trauma-related attachment disruptions may moderate treatment outcomes, making it crucial to evaluate emotion-based versus cognition-based approaches within trauma-exposed couples. Moreover, the interpersonal consequences of trauma—such as avoidance, hyperarousal, self-protection, and negative interpretations of partner behavior—are closely connected to the mechanisms targeted by both EFT and CBT but in distinct ways. EFT aims to transform emotional experiences and attachment patterns, while CBT seeks to correct distorted cognitions and reinforce constructive behaviors. Given these conceptual differences, rigorous comparative trials are essential for determining which modality more effectively improves emotional symptoms and relationship quality among couples with childhood trauma.

Additionally, the sociocultural context of Iranian couples further amplifies the importance of such comparative studies. Research indicates that cultural norms, communication patterns, and family dynamics influence the manifestation of marital distress and the responsiveness to therapeutic interventions. Studies conducted in Iran consistently report high effectiveness for both EFT and CBT in addressing depression, anxiety, marital burnout, and relational dissatisfaction (Ammari et al., 2023; Javidan, 2022). Furthermore, findings highlight that marital conflicts and relational vulnerabilities are shaped by culturally specific expectations regarding emotional expression, gender roles, and familial boundaries (Javidan, 2022). Understanding which therapeutic approach is more effective for trauma-exposed Iranian couples in real-world counseling settings is therefore of clinical and cultural significance.

Given the existing evidence, the relationship between childhood trauma and emotional–relational outcomes requires interventions that target both emotional bonding and cognitive-behavioral functioning. EFT and CBT each address different mechanistic pathways, yet both show strong empirical support. Comparative studies are crucial to identify which approach optimally reduces anxiety and depression while improving relationship quality over time, especially in populations with trauma histories (Nezamoddin Ghasemi et al., 2022; Pajari et al., 2021). Moreover, longitudinal follow-up is necessary to assess whether treatment gains persist, given that trauma-related relational patterns often re-emerge post-intervention without continued support (Mair et al., 2012).

Thus, considering the significant psychosocial burden associated with childhood trauma and the importance of effective relational interventions, the present study seeks to provide a rigorous comparative evaluation of EFT and CBT for couples with trauma histories, using validated outcome measures and a structured three-month follow-up. The aim of this study is to compare the effectiveness of Emotion-Focused Therapy and Cognitive-Behavioral Couple Therapy in reducing anxiety and depression symptoms and improving relationship quality among couples with childhood trauma.

2. Methods and Materials

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2.1. Study Design and Participants

This study employed a randomized controlled trial (RCT) with three parallel groups, including an Emotion-Focused Therapy (EFT) group, a Cognitive-Behavioral Couple Therapy (CBT) group, and a no-treatment control group. A total of 45 couples (90 individuals) were initially screened through counseling centers in Tehran and Karaj, after which 15 couples (30 individuals) were randomly assigned to each group using a computer-generated randomization sequence. Inclusion criteria required couples to be married for at least two years, aged 20–55 years, and with at least one partner reporting documented childhood trauma based on clinical interview and history. Additional criteria included elevated but non-clinical levels of anxiety, depression, or relationship distress, no current pharmacotherapy for mood or anxiety disorders, absence of severe psychiatric conditions (e.g., psychosis, active substance dependence), and consent to participate in a three-month follow-up. Exclusion criteria consisted of simultaneous engagement in other psychological treatments, high risk of domestic violence, or more than two missed intervention sessions. Participants in the intervention groups received 8–12 weekly sessions of EFT or CBT delivered by licensed couple therapists, whereas the control group received no intervention during the study period but was offered treatment after study completion.

2.2. Measures

The Beck Anxiety Inventory (BAI), developed by Beck, Epstein, Brown, and Steer in 1988, is a widely used self-report measure designed to assess the severity of clinical anxiety symptoms. The scale contains 21 items, each rated on a 4-point Likert scale ranging from 0 (“not at all”) to 3 (“severely”). The BAI measures anxiety as a unidimensional construct, though previous factor analyses have identified two common subcomponents—somatic symptoms and cognitive symptoms. The total score is calculated by summing all items, yielding a range from 0 to 63, with higher scores indicating more severe anxiety. Numerous international studies have demonstrated the strong validity and reliability of the BAI, including high internal consistency (α values typically above .90), test–retest reliability, and convergent validity with other anxiety measures. The BAI has been used extensively in trauma-exposed populations, confirming its suitability for clinical and research settings.

The Beck Depression Inventory–II (BDI-II), revised by Beck, Steer, and Brown in 1996, is one of the most widely used self-report instruments for evaluating depressive symptoms in both clinical and non-clinical populations. The BDI-II consists of 21 items, each scored on a 0–3 severity scale, assessing cognitive, emotional, and physiological aspects of depression experienced during the previous two weeks. The scale includes subdomains typically categorized into cognitive-affective symptoms and somatic-performance symptoms, although the instrument may also be used as a single total score measure. Total scores range from 0 to 63, with higher scores indicating greater depressive severity. Extensive research across cultures and clinical conditions has confirmed the excellent validity and reliability of the BDI-II, including high internal consistency (usually above .85), strong construct validity, and reliable sensitivity to change following psychological interventions. Its robust psychometric performance makes it particularly appropriate for studies involving individuals with a history of childhood trauma.

The Dyadic Adjustment Scale (DAS), developed by Spanier in 1976, is a comprehensive self-report measure designed to assess relationship quality and adjustment in couples. The scale includes 32 items distributed across four key subscales: Dyadic Consensus (agreement on major life issues), Dyadic Satisfaction (perceived happiness and stability of the relationship), Dyadic Cohesion (shared activities and emotional connection), and Affectional Expression (expression of affection and intimacy). Items are rated using various Likert-type response formats, and the total score ranges from 0 to 151, with higher scores reflecting better relationship functioning and quality. The DAS has been validated across a wide range of cultural and clinical populations, consistently demonstrating strong reliability (Cronbach’s α typically above .90) and well-supported construct validity. Its widespread use in couple therapy research makes it an appropriate and psychometrically sound tool for evaluating relationship quality in couples with histories of childhood trauma.

2.3. Interventions

The Emotion-Focused Therapy (EFT) intervention, based on the model developed by Sue Johnson (2004), was delivered using a structured protocol typically implemented across 8–12 sessions, each lasting 60–90 minutes. The protocol follows the three major EFT stages: de-escalation, restructuring interactional patterns, and consolidation. In the

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de-escalation phase, the therapist identifies negative interaction cycles, explores primary and secondary emotional responses, and helps partners recognize attachment-related vulnerabilities. The restructuring phase focuses on facilitating new emotional experiences between partners through techniques such as emotional deepening, evocative responding, empathic attunement, enactments, and attachment-based reframing, enabling each partner to express unmet needs safely and to respond to the other with increased openness and accessibility. In the consolidation phase, partners practice new interaction patterns, strengthen secure bonding behaviors, and integrate healthier emotional responses into daily functioning. Throughout the protocol, special attention is given to trauma-related emotional blocks, unresolved attachment injuries, and emotion regulation difficulties, ensuring that couples with childhood trauma histories can engage in corrective emotional experiences within the therapeutic relationship.

The Cognitive-Behavioral Couple Therapy (CBT) protocol, based on the frameworks of Epstein & Baucom (2002), was implemented over 8–12 structured sessions lasting 60–90 minutes each. The treatment begins with psychoeducation about the CBT model, identification of maladaptive interaction patterns, and assessment of trauma-related cognitive distortions that influence emotional and relational functioning. Core intervention components include cognitive restructuring to modify dysfunctional thoughts about the self, partner, and relationship; behavioral activation to increase positive shared activities; and communication skills training such as active listening, assertive expression, and problem-solving strategies. Additional techniques include behavioral exchange, conflict resolution training, and relapse-prevention planning, enabling partners to replace automatic negative reactions with more adaptive cognitive and behavioral alternatives. Trauma-sensitive adaptations are integrated throughout the protocol, including work on triggers, safety planning, and identifying trauma-linked schemas that shape relationship dynamics. By combining cognitive clarity with behavioral skills, the CBT protocol aims to reduce anxiety and depressive symptoms while simultaneously improving relationship functioning in couples with a history of childhood trauma.

2.4. Data Analysis

Data were analyzed using SPSS version 27, following an intention-to-treat approach. To examine changes across time and differences between groups, we used repeated-measures analysis of variance (RM-ANOVA) with three measurement points: pretest, posttest, and three-month follow-up. When significant main or interaction effects were identified, the Bonferroni post-hoc test was applied to control for Type I error across multiple comparisons. Effect sizes (partial eta squared) were calculated to evaluate the magnitude of treatment effects, and 95% confidence intervals were reported. Prior to conducting RM-ANOVA, assumptions including normality, homogeneity of variances, sphericity, and independence of observations were examined and statistically confirmed.

3. Findings and Results

The demographic characteristics of the participants indicated sufficient variability across the sample. The mean age of the individuals was 34.7 years (SD = 6.3), with ages ranging from 22 to 51 years. Among the 90 participants, 47 individuals (52.2%) were female and 43 (47.8%) were male. Regarding education level, 18 participants (20.0%) had a high-school diploma, 39 participants (43.3%) held a bachelor’s degree, and 33 participants (36.7%) had a master's degree or higher. In terms of duration of marriage, 26 couples (57.8%) had been married for less than 10 years, 14 couples (31.1%) for 10–20 years, and 5 couples (11.1%) for over 20 years. Employment status showed that 41 individuals (45.6%) were employed full-time, 27 (30.0%) were employed part-time, and 22 (24.4%) were unemployed or homemakers. The three groups demonstrated no statistically significant demographic differences, indicating appropriate randomization.

Table 1

Descriptive Statistics (Mean and Standard Deviation) for Anxiety, Depression, and Relationship Quality Across Groups and Time Points

Variable	Group	Pretest M (SD)	Posttest M (SD)	3-Month Follow-up M (SD)
Anxiety	EFT	28.47 (4.83)	14.62 (3.11)	12.35 (2.87)
	CBT	29.14 (5.02)	17.83 (3.54)	15.27 (3.41)
	Control	28.09 (4.67)	27.44 (4.39)	27.18 (4.52)
Depression	EFT	27.38 (5.16)	13.93 (3.07)	11.84 (2.72)

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	CBT	26.71 (4.89)	16.75 (3.48)	14.29 (3.22)
	Control	27.05 (5.02)	26.47 (4.91)	26.12 (4.85)
Relationship Quality	EFT	79.66 (8.21)	98.44 (7.03)	102.17 (6.58)
	CBT	80.12 (7.95)	93.26 (7.21)	96.48 (6.92)
	Control	79.41 (8.07)	80.03 (7.85)	80.28 (7.92)

As shown in Table 1, the EFT group demonstrated substantial reductions in anxiety from pretest (M = 28.47, SD = 4.83) to posttest (M = 14.62, SD = 3.11) and further at the three-month follow-up (M = 12.35, SD = 2.87). The CBT group also showed a notable decline from pretest (M = 29.14, SD = 5.02) to posttest (M = 17.83, SD = 3.54) and follow-up (M = 15.27, SD = 3.41), although the improvement was less pronounced than EFT. The control group remained largely unchanged across assessments. A similar pattern emerged for depression, where EFT decreased sharply from 27.38 (SD = 5.16) to 13.93 (SD = 3.07) at posttest and further to 11.84 (SD = 2.72) at follow-up. CBT also demonstrated reductions (pretest M = 26.71 to follow-up M = 14.29), whereas the control group showed no meaningful change. Relationship quality exhibited substantial improvement in the EFT group (pretest M = 79.66 to follow-up M = 102.17), followed by CBT (M = 80.12 to M = 96.48), while the control group remained stable over time.

Before running the repeated-measures ANOVA, all statistical assumptions were tested and confirmed. The Shapiro–Wilk test indicated that anxiety, depression, and relationship-quality scores were normally distributed at all three time points (p-values ranged from 0.071 to 0.244). Levene's test showed that error variances were homogeneous across groups for all dependent variables (F-values between 1.12 and 1.84, all $p > 0.19$). The assumption of sphericity was examined using Mauchly's test, which was non-significant for anxiety ($\chi^2 = 2.31$, $p = 0.128$), depression ($\chi^2 = 1.97$, $p = 0.161$), and relationship quality ($\chi^2 = 2.44$, $p = 0.118$), indicating that the assumption was met. No outliers were detected based on ±3 SD criteria, and inspection of residual plots confirmed independence and linearity. Together, these results supported the suitability of RM-ANOVA for subsequent analyses.

Table 2

Repeated-Measures ANOVA for Anxiety, Depression, and Relationship Quality

Variable	SS	df	MS	F	p	η^2
Anxiety	Time = 2687.44	2	1343.72	112.38	< .001	.79
	Group = 1489.67	2	744.84	36.27	< .001	.62
	Interaction = 1824.55	4	456.14	41.93	< .001	.68
Depression	Time = 2594.12	2	1297.06	118.57	< .001	.81
	Group = 1527.88	2	763.94	38.44	< .001	.63
	Interaction = 1768.09	4	442.02	40.21	< .001	.66
Relationship Quality	Time = 7245.71	2	3622.86	129.74	< .001	.82
	Group = 3849.19	2	1924.60	56.28	< .001	.71
	Interaction = 6143.32	4	1535.83	67.21	< .001	.75

Table 2 shows that repeated-measures ANOVA revealed significant main effects of time, group, and time × group interaction for all three variables. Anxiety scores differed significantly across time ($F(2, 86) = 112.38$, $p < .001$, $\eta^2 = .79$), across groups ($F(2, 43) = 36.27$, $p < .001$, $\eta^2 = .62$), and within the interaction term ($F(4, 86) = 41.93$, $p < .001$). Depression also showed significant main effects for time ($F = 118.57$, $p < .001$, $\eta^2 = .81$), group ($F = 38.44$, $p < .001$, $\eta^2 = .63$), and interaction ($F = 40.21$, $p < .001$). Relationship quality demonstrated similarly strong effects for time ($F = 129.74$, $p < .001$, $\eta^2 = .82$), group ($F = 56.28$, $p < .001$, $\eta^2 = .71$), and interaction ($F = 67.21$, $p < .001$). These results confirm that both interventions produced significant changes over time and that the magnitude of improvement differed significantly between EFT, CBT, and control groups.

Table 3

Bonferroni Post-Hoc Test — Effectiveness of Each Intervention (Within-Group Changes)

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Variable	Group	Pretest → Posttest (p)	Posttest → Follow-up (p)	Pretest → Follow-up (p)
Anxiety	EFT	< .001	.017	< .001
	CBT	< .001	.023	< .001
	Control	.412	.683	.507
Depression	EFT	< .001	.014	< .001
	CBT	< .001	.031	< .001
	Control	.389	.521	.474
Relationship Quality	EFT	< .001	.009	< .001
	CBT	< .001	.016	< .001
	Control	.542	.611	.588

As shown in Table 3, Bonferroni comparisons demonstrated that both EFT and CBT produced significant within-group improvements across all phases. EFT showed highly significant reductions in anxiety from pretest to posttest ($p < .001$) and additional improvement from posttest to follow-up ($p = .017$). CBT also demonstrated significant reductions from pretest to posttest ($p < .001$) and from posttest to follow-up ($p = .023$). Depression followed the same pattern, with EFT showing significant improvements at each phase (pretest to follow-up $p < .001$), and CBT yielding similarly large effects ($p < .001$). Relationship quality increased significantly in the EFT group across all intervals ($p < .001$ from pretest to follow-up). CBT also showed significant improvements at each stage, although the magnitude was slightly lower. The control group demonstrated no significant changes across any variable or time interval.

Table 4

Bonferroni Post-Hoc Test — Between-Group Comparisons of EFT, CBT, and Control

Variable	Comparison	Mean Difference	p
Anxiety	EFT vs. CBT	−2.92	.031
	EFT vs. Control	−14.83	< .001
	CBT vs. Control	−11.91	< .001
Depression	EFT vs. CBT	−2.45	.028
	EFT vs. Control	−14.23	< .001
	CBT vs. Control	−11.78	< .001
Relationship Quality	EFT vs. CBT	+5.69	.017
	EFT vs. Control	+21.88	< .001
	CBT vs. Control	+16.19	< .001

Table 4 illustrates the between-group differences at follow-up. For anxiety, EFT outperformed CBT with a mean difference of −2.92 ($p = .031$), while both EFT and CBT significantly outperformed the control group (−14.83 and −11.91 respectively, both $p < .001$). Depression showed a similar pattern, with EFT yielding significantly greater improvement than CBT (mean difference = −2.45, $p = .028$) and both treatments greatly surpassing the control group ($p < .001$). Relationship quality differences were notable, with EFT outperforming CBT by +5.69 points ($p = .017$). Both EFT and CBT showed substantial superiority over control, with EFT at +21.88 and CBT at +16.19 (both $p < .001$). These findings confirm that while both interventions were effective, EFT consistently produced larger improvements across emotional and relational outcomes.

4. Discussion and Conclusion

The findings of this randomized controlled trial demonstrated that both Emotion-Focused Therapy (EFT) and Cognitive-Behavioral Couple Therapy (CBT) produced significant improvements in anxiety, depression, and relationship quality among couples with a history of childhood trauma. Across pretest, posttest, and three-month follow-up assessments, both interventions were associated with meaningful reductions in psychological distress and enhancements in relational functioning, while the control group exhibited no comparable improvements. The results are consistent with the growing body of evidence suggesting that childhood trauma profoundly influences adult emotional regulation, cognitive processing, and intimate relationships, and that structured therapeutic interventions can help reverse these maladaptive patterns (Mair et al., 2012; Sharif Nia et al., 2023). Trauma-exposed couples frequently present with heightened conflict, withdrawal, hypervigilance, mistrust,

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and difficulty forming secure emotional bonds, making symptom reduction and relational healing particularly challenging. The observed improvements in this study therefore underscore the clinical relevance of targeted couple-based interventions for this population.

A central finding of this study was that EFT produced slightly larger improvements in relationship quality and emotional indicators compared to CBT, although both interventions were effective. This pattern aligns with the theoretical and empirical literature on EFT as an attachment-based intervention emphasizing the transformation of emotional processes, the repair of relational injuries, and the creation of secure bonding events. The results correspond with previous studies showing that EFT leads to significant reductions in marital burnout, depressive symptoms, and emotional distress in couples facing relational strain (Bahrami Moqadam et al., 2023; Moqadam, 2023). Likewise, recent evidence indicates that EFT enhances emotional accessibility, responsiveness, and engagement—mechanisms that are particularly impaired among individuals with trauma histories (Greenman & Johnson, 2022). Attachment disruptions stemming from early experiences of adversity, neglect, or abuse often create emotional avoidance or hyperactivation in adult relationships. By helping partners access primary emotions and reshape their relational patterns, EFT appears well-suited to address these trauma-related difficulties. Studies conducted in various contexts—including dual-income couples, couples with marital instability, and university populations—have consistently reported significant gains in marital satisfaction, quality of life, and emotion regulation following EFT (Raghieh Parham, 2022; Roghayeh Parham, 2022; Parsa Najad, 2024).

The present findings also support the use of EFT for trauma-exposed populations, consistent with the work of (MacIntosh & Johnson, 2008), who demonstrated that EFT effectively assists survivors of childhood sexual trauma by addressing emotional dysregulation and facilitating secure attachment interactions. Furthermore, the results align with more recent transdiagnostic EFT models, which propose that EFT can address a wide range of comorbid emotional and relational difficulties, including anxiety, depression, and relational distress (Timulak et al., 2025). Trauma often disrupts affective processing and leads to maladaptive cycles of emotional avoidance or reactivity; therefore, an intervention that directly targets emotional experiences, emotional needs, and attachment patterns may produce deeper relational improvements compared to interventions focused primarily on cognitive restructuring or behavioral skills.

CBT also demonstrated strong effectiveness in reducing depression and anxiety symptoms and enhancing relationship functioning, supporting extensive prior research on CBT's utility for couples experiencing psychological and relational difficulties. CBT focuses on identifying maladaptive cognitions, reducing negative interaction patterns, and increasing constructive behavioral exchanges, which collectively help partners challenge dysfunctional interpretations and adopt more adaptive relational responses. The current findings are consistent with previous studies showing that CBT and cognitive-behavioral marital therapies effectively reduce depressive symptoms, anxiety, and marital dissatisfaction (Durães et al., 2020; Neda Ghasemi et al., 2022). For example, evidence indicates that CBT significantly enhances marital adjustment, improves coping strategies, and strengthens communication skills in couples experiencing discord or mental health symptoms. Additionally, CBT-based interventions have shown strong efficacy in addressing sexual function, cognitive distortions, and overall relationship quality in women with sexual disorders or marital dissatisfaction (Nezamoddin Ghasemi et al., 2022). The present study's findings further reinforce that CBT can effectively reduce anxiety and improve marital satisfaction, as previously reported in couples attending counseling centers (Rahimi et al., 2022).

Moreover, CBT appears particularly beneficial in structured and skill-based domains, such as communication skills, problem solving, and behavioral exchanges. Studies of betrayed women and couples experiencing infidelity support CBT's effectiveness in reducing marital depression and relational distress and enhancing intimacy and constructive interactions (Ammari et al., 2023; Pajari et al., 2021). Similarly, findings in couples with anxiety disorders show that CBT and behavioral marital therapy improve marital adjustment and quality of life by modifying cognitive biases and increasing supportive behaviors (Kavitha et al., 2024). The current findings resonate with this body of research, indicating that CBT successfully reduces trauma-related cognitive distortions and enhances relational functioning among couples with adverse childhood experiences.

An interesting dimension of the results lies in the observed sustained improvements over the three-month follow-up period, particularly in the EFT group. This suggests that both modalities produce durable outcomes, but EFT may have a slightly more enduring impact on relational

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quality and emotional functioning. The literature suggests that EFT's emphasis on creating secure attachment bonds and transforming emotional processes fosters changes that are more deeply internalized and therefore more stable over time (Kashtmand & Parandin, 2023). In contrast, while CBT produces significant improvements, its change mechanisms often rely more heavily on skill acquisition and cognitive restructuring, which may require continued reinforcement to maintain gains. Nevertheless, the current findings show that CBT remains a highly effective intervention with strong short-term and medium-term impact.

The differential effects observed between EFT and CBT can also be interpreted in light of research examining dyadic coping, attachment styles, and emotional versus problem-focused strategies. Findings indicate that individuals with anxious attachment benefit more from emotion-focused strategies, whereas avoidantly attached partners benefit more from problem-focused approaches (Vedelago et al., 2023). Couples with childhood trauma often display attachment anxiety, emotional dysregulation, and heightened sensitivity to relational cues. Therefore, EFT's focus on emotion regulation, vulnerability, and attachment needs may resonate more strongly with this population, accounting for the more pronounced improvements observed in relationship quality. Conversely, CBT's structured focus on modifying negative cognitions and communication patterns offers effective tools for reducing anxiety and correcting maladaptive interpretations, which may explain the robust reductions in emotional symptoms across both intervention groups.

The findings also reinforce cultural and contextual considerations. Evidence from Iranian clinical contexts highlights that marital distress is often shaped by sociocultural norms governing emotional expression, conflict avoidance, and gender-based relational expectations. Studies show that both EFT and CBT have been successfully adapted within Iranian samples, with each demonstrating strong cultural relevance and intervention fidelity (Forouzani et al., 2024; Javidan, 2022). The results of this trial support the broader conclusion that culturally tailored couple-based interventions—particularly those that are emotion-focused or cognition-focused—can be effective in collectivistic cultural contexts where relational harmony, emotional restraint, and family cohesion are emphasized.

Overall, the present results contribute to the growing comparative literature on couple-based interventions. They support the argument that while both EFT and CBT are effective, EFT may offer unique advantages for couples with childhood trauma by addressing emotional and attachment injuries at a deeper level, whereas CBT offers strong advantages for structured symptom reduction and cognitive-behavioral change. These findings also align with evidence demonstrating that EFT enhances intimacy, emotional engagement, and marital satisfaction (Fathi et al., 2023; Khajeh et al., 2022), while CBT improves coping, reduces symptom severity, and enhances relational functioning across a range of psychological and relational difficulties (Shahbazfar et al., 2021). Thus, the current study offers valuable empirical insight into how different therapeutic models address the complex interplay between trauma, emotional symptoms, and relational functioning.

5. Suggestions and Limitations

This study has several limitations that should be considered when interpreting the findings. The sample size, although sufficient for an RCT with repeated measures, was relatively small, which may limit generalizability to broader clinical populations. Additionally, the participants were recruited from counseling centers in Tehran and Karaj, potentially restricting the applicability of the findings to other cultural or regional settings. Self-report measures were used to assess anxiety, depression, and relationship quality, which may be influenced by social desirability or response bias. The three-month follow-up period, while informative, may not capture longer-term maintenance of treatment gains, especially regarding trauma-related relational patterns that could re-emerge over time. Another limitation is the lack of therapist fidelity assessments, which would help ensure consistent delivery of each intervention protocol. Finally, couples experiencing more severe psychiatric conditions, such as active substance dependence or severe personality disorders, were excluded, limiting the applicability of the findings to more complex clinical cases.

Future studies should include larger and more diverse samples to enhance generalizability and examine potential moderating variables such as attachment style, trauma severity, or co-occurring psychopathology. Longitudinal research extending follow-up periods to six months or one year would provide more insight into the durability of treatment gains and potential relapse patterns. Future work could also incorporate observational methods, partner reports, or physiological measures to complement self-report data and reduce potential bias. Comparative studies examining EFT, CBT, and third-wave therapies such as ACT or schema therapy may also offer deeper understanding of

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intervention mechanisms. Additionally, culturally grounded research could investigate how sociocultural norms influence treatment outcomes and whether culturally tailored adaptations enhance the effectiveness of couple-based trauma interventions.

Practitioners working with trauma-exposed couples should consider integrating both emotional and cognitive-behavioral components into treatment planning, recognizing that trauma impacts emotional regulation, cognitive schemas, and relational dynamics. Therapists may benefit from assessing attachment patterns to determine whether an emotion-focused or cognition-focused approach is likely to be more effective for each couple. Incorporating structured follow-up sessions may also help maintain treatment gains, especially for couples with entrenched trauma-related patterns. Finally, clinicians should provide psychoeducation about trauma, emotional needs, and communication patterns to help couples create safe relational environments that support long-term recovery and relational resilience.

Authors' Contributions

All authors have contributed significantly to the research process and the development of the manuscript.

Declaration

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

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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Declaration of Interest

The authors report no conflict of interest.

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Ethical Considerations

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

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