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Original Article

Effectiveness of Healing Codes Intervention and Emotion-Focused Therapy on Help-Seeking and Social Competence among Female Adolescents with Depressive Symptoms

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Abstract

Background and Objective: Adolescent depression constitutes a profound mental health challenge, frequently precipitating deficits in psychosocial functioning, notably in help-seeking behaviors and social competence. The present study aimed to evaluate and contrast the efficacy of Healing Codes Intervention (HCI) and Emotion-Focused Therapy (EFT) in bolstering these domains among female adolescents exhibiting depressive symptoms.

Materials and Methods: The study employed a pretest-posttest-follow-up design and targeted the entire cohort of 2,200 female secondary high school students in Ahvaz, Iran, during the 2024–2025 academic year. Through clustered random sampling, 45 participants meeting depressive symptom criteria—verified by DSM-5 guidelines and the Beck Depression Inventory (BDI-II)—were recruited and randomly allocated to three equal groups (n=15 per group): HCI (14 weekly 90-min sessions), EFT (eight weekly 90-min sessions), and a no-intervention control group. Outcomes were assessed via the Help-Seeking Behavior Questionnaire and the Social Competence Scale (SCS). In addition, data were analyzed using repeated-measures analysis of variance (ANOVA).

Results: Both HCI and EFT cohorts evinced marked and enduring elevations in help-seeking behavior and social competence relative to controls ($P<0.001$; significant group×time interactions: help-seeking $F=86.33$, $\eta=0.70$; social competence $F=333.46$, $\eta=0.84$). These outcomes persisted through the follow-up phase. Although EFT yielded modestly superior immediate outcomes (e.g., a post-test social competence difference favoring EFT over HCI that was significant at $P=0.015$), intergroup disparities in therapeutic impact at follow-up were not statistically significant.

Conclusions: These results affirm HCI and EFT as viable modalities for ameliorating psychosocial impairments associated with adolescent depression. Their incorporation into school-based and clinical curricula is advocated to cultivate adaptive help-seeking behaviors and interpersonal proficiencies in affected youth.

Keywords: Depression, Emotion-focused therapy, Help-seeking behavior, Social competence

Background

Adolescence is a critical developmental period marked by significant neurobiological and psychosocial changes, often rendering individuals vulnerable to the onset or exacerbation of mental health disorders [1]. Among these, depression stands out as a pervasive condition, affecting a considerable proportion of the student population globally [2]. Notably, adolescent girls exhibit higher rates of depression and are more likely to report internalizing symptoms compared to boys, who often show lower help-seeking behavior tendencies influenced by gender norms. In educational settings, adolescent depression manifests not merely as mood disturbances but as profound functional impairments. These impairments critically undermine academic success, interpersonal relationships, and future vocational outcomes [3]. Depressed students frequently exhibit withdrawal, diminished motivation, and a reluctance to engage with necessary support systems, perpetuating a cycle of distress and isolation. Addressing this vulnerability requires targeted interventions focused on strengthening core psychosocial protective factors to mitigate the pervasive, long-term impact of the disorder [4].

Help-seeking behavior is a proactive coping strategy defined as the willingness and ability to access necessary assistance, resources, or information to overcome a problem [5]. For students experiencing depression, the inability or unwillingness to seek help—whether from peers, family, teachers, or mental health professionals—is a significant barrier to recovery and academic persistence [6]. Research consistently indicates that low help-seeking propensity in depressed youth is highly predictive of chronic mental health problems, delayed diagnosis,

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and increased suicidal ideation [7, 8]. Therefore, enhancing this behavior is a primary therapeutic target, shifting passive suffering into active agency.

Social competence refers to the ability to manage social interactions effectively and appropriately, navigate complex social situations, and maintain satisfying and meaningful relationships [9]. In depressed adolescents, social competence is often severely compromised, characterized by deficits in emotional regulation, impaired communication skills, and difficulty forming secure relational bonds [10]. These social difficulties further exacerbate depressive symptoms, often leading to social isolation, peer rejection, and reduced self-esteem, which are themselves risk factors for continued depressive episodes [11, 12]. Consequently, successful intervention must aim to restore skills for constructive social engagement.

The Healing Codes Intervention (HCI) is a novel, energy-based therapeutic approach predicated on the hypothesis that physical and emotional distress stems from cellular memory stress or "bad memory pictures" [13]. This technique involves specific, repeated hand positions intended to activate key energy centers in the body, thereby facilitating emotional healing and stress reduction [14]. Although rooted in alternative energy healing assumptions rather than mainstream empirical frameworks, preliminary studies—primarily in non-clinical or adjunctive contexts—have suggested potential benefits in reducing anxiety and improving emotional states. However, HCI lacks robust evidence from large-scale, randomized controlled trials in mainstream clinical psychology, and its effects on physiological markers of stress remain preliminary and not extensively replicated in reputable scientific literature. Preliminary studies, primarily outside the scope of mainstream clinical psychology, have suggested that HCI can be effective in reducing general anxiety, improving emotional states, and positively impacting physiological markers of stress [15]. However, its specific application and comparative efficacy against established, evidence-based psychotherapies in improving complex psychosocial variables, such as help-seeking behaviors and social competence in clinically depressed adolescents, remain largely unexplored within academic literature.

Emotion-Focused Therapy (EFT), an empirically supported humanistic and experiential approach, views emotion as central to the organization of experience and the construction of the self [16]. The core mechanism of change in EFT involves helping clients access, experience, regulate, and transform maladaptive primary emotions (e.g., core shame, abandonment fear) into adaptive, resource-providing emotions [17]. Extensive clinical research has established EFT's robust efficacy in treating various conditions, including major depression, by enhancing emotional intelligence, self-compassion, and strengthening interpersonal functioning [18, 19]. While the principles of EFT logically address the core emotional and relational deficits underlying poor help-seeking behaviors and compromised social competence, a direct comparison with emerging therapies, such as HCI, is necessary to inform best clinical practice.

Despite the established need for effective and scalable interventions in adolescent depression, comparative research on novel, energy-based therapies like HCI against established, process-oriented therapies like EFT is notably scarce. The current scientific literature provides limited empirical guidance for clinicians seeking to optimize treatment selection to improve specific, critical psychosocial outcomes, such as help-seeking behaviors and social competence. This research gap is particularly relevant for school-based prevention and treatment programs, where accessible interventions could promote early help-seeking behaviors and social competence to prevent long-term impairment. Therefore, the necessity of this research stems from the need to generate evidence-based comparative data.

Objectives

The primary objective of the present study was to determine the comparative effectiveness of the HCI and EFT in enhancing help-seeking behavior and social competence among female high school students experiencing symptoms of depression. A secondary objective was to compare the sustainability of the effects of the two interventions at one-month follow-up.

Materials and Methods

Design and Participants

This investigation adopted a quasi-experimental pretest-posttest-follow-up design with a no-treatment control group. The sample size of 45 participants (n=15 per group) was determined a priori using G*Power 3.1 software for repeated-measures ANOVA (within-between interaction), assuming a medium effect size (f=0.40), α=0.05, power=0.80, three groups, three measurements, and a correlation among repeated measures of 0.70, yielding a recommended total sample size of 42. The target population encompassed 2,200 female high school students in Ahvaz, Iran, during the 2024–2025 academic year. A multi-stage cluster random sampling design was implemented: four districts were randomly selected, followed by two

schools per district and three classes per school. From the 120 students screened via the Beck Depression Inventory (BDI-II) for moderate-to-severe scores, eligible participants underwent DSM-5-structured interviews by a school counselor, yielding a final cohort of 45 students with confirmed depressive symptoms. Participants were then randomly allocated equally (n=15 per group) to the HCI, EFT, or no-treatment control group. Inclusion criteria included female gender, informed consent (from both students and parents), and scores exceeding clinical thresholds on the BDI-II; exclusion criteria included comorbid psychotic disorders, concurrent psychotherapy, or more than two session absences. All procedures complied with institutional ethical standards and prioritized consent, privacy, and post-study EFT access for the control group.

Procedure

Data collection occurred across three phases: pre-test (pre-intervention), post-test (immediately post-intervention), and follow-up (one month later). The HCI group underwent 14 weekly 90-min sessions, while the EFT group completed eight similar sessions. The control group continued routine schooling without therapeutic input but participated fully in all assessments. EFT, delivered by a certified therapist, adhered to Greenberg's experiential framework, emphasizing emotional processing through techniques such as two-chair and empty-chair dialogues to restructure maladaptive emotional schemas. The HCI sessions, facilitated by a trained practitioner, incorporated structured self-healing exercises based on specific hand positions directed at four primary healing centers (throat, jaw, temples, and bridge of the nose), performed for approximately 6–10 min per exercise while focusing on stress-related memories or affirmations; participants were also encouraged to practice these hand position exercises daily at home for reinforcement. Detailed outlines of the HCI (14 sessions) and EFT (8 sessions) protocols are presented in Tables 1 and 2, respectively. Treatment fidelity was monitored through session checklists completed by the therapists and periodic supervision to ensure adherence to the respective protocols.

Table 1. Conceptual framework and session outline for the HCI.

Session and Key Theme	Session Overview
Sessions 1–2: Building Basic Insight	Overview of self-directed healing methods; exploration of the origins of mental discomfort and emotional turmoil; development of a supportive therapeutic alliance.
Sessions 3–4: Present-Moment Attention and Self-Monitoring	Essential exercises in mindful presence; impartial observation of mental patterns and sensations; guided body awareness practices.
Sessions 5–6: Fostering Kindness and Silencing Inner Judgment	Methods to nurture self-acceptance; strategies to reframe and soften severe self-judgment (e.g., through reflective journaling).
Sessions 7–8: Managing Emotional Responses	Recognition of affective cues; acquisition of flexible techniques for handling overwhelming negativity; tools for enduring emotional challenges.
Sessions 9–10: Identifying Principles and Direction	Articulation of individual and educational priorities; synchronization of routines with fundamental goals; enhancement of sense of purpose and commitment.
Sessions 11–12: Repairing Connections	Examination of relational conflicts; exercises in granting pardon (to oneself and others); refinement of interaction abilities.
Sessions 13–14: Synthesis and Sustainability	Reinforcement of acquired competencies; creation of a customized routine for ongoing self-nurturing and strategies to prevent setbacks in school and mood stability.

Table 2. Conceptual framework and session outline for the EFT Protocol

Session and Key Theme	Session Overview
Sessions 1–2: Forming Bonds and Evaluation	Creation of a robust affective connection; detection and charting of detrimental emotional loops tied to depressive states and school-related pressures.
Sessions 3–4: Uncovering Core Feelings	Application of probing inquiries to intensify affective encounters; distinction between innate helpful/harmful emotions and subsequent defensive reactions.
Sessions 5–6: Dialogue for Internal Resolution	Enabling conversation among opposing self-aspects (e.g., judgmental side versus vulnerable core) to promote unity and self-comfort.
Session 7: Addressing Unresolved Attachments	Exploration of lingering affective matters with key figures to attain reconciliation and affective completion.
Session 8: Synthesis and Reinforcement	Evaluation of affective shifts; solidification of emerging response patterns; promotion of stable self-connection.

Instruments

The Help-Seeking Behavior Questionnaire, adapted from Ryan and Pintrich's foundational framework, comprises 14 items on a 5-point Likert scale (1=Strongly Disagree to 5=Strongly Agree) that assess students' inclinations to seek academic and personal support from diverse sources, such as educators and peers. Total scores range from 14 to 70, with higher values denoting greater adaptive help-seeking behaviors [20]. Psychometric evaluations have affirmed its robustness, including a Cronbach's α of 0.84 in Persian-validated studies [21], which was mirrored closely in the present cohort (α=0.85).

The Social Competence Scale (SCS), a comprehensive 44-item self-report measure, gauges perceived proficiency across social domains, including emotional regulation, relational dialogue,

and proactive engagement. Rated on a 4-point scale, it yields scores from 44 to 176, with higher scores indicating superior social competence [22]. It is noteworthy that social competence was assessed solely via self-report, as multi-informant ratings (e.g., from teachers or parents) were not feasible within the school-based constraints of this study. Bolstered by robust construct validity, the scale demonstrates commendable reliability among Iranian youth (α=0.81) [23], with internal consistency in this sample at α=0.82.

Data Analysis

Descriptive statistics (mean and standard deviation) were initially calculated. The primary analysis method was a repeated-measures analysis of variance (ANOVA), used to assess the main effects of time and group, and their interaction, on help-seeking behaviors and social competence scores across the pre-test, post-test, and follow-up phases. Prior to conducting the repeated-measures ANOVA, key statistical assumptions were systematically evaluated to ensure analytical integrity. Normality was confirmed using Shapiro-Wilk tests, which yielded non-significant results (P>0.05) for the dependent variables across groups and phases. Homogeneity of variance-covariance matrices was supported by Box's M test (P>0.05) and Levene's test (P>0.05). However, Mauchly's test of sphericity indicated a violation (P<.05); therefore, the Greenhouse-Geisser correction was applied to adjust the degrees of freedom for the within-subjects effects and interactions.

Results

The study sample comprised 45 female high school students from Ahvaz, Iran, with a mean age of 16.42 years (SD=0.72). Baseline demographic characteristics, including socioeconomic status and academic performance, were comparable across the HCI, EFT, and control groups, ensuring group equivalence at pre-test.

As illustrated in Table 3, pre-test means for help-seeking behaviors were comparable across groups (HCI: M=35.40, SD=1.99; EFT: M=34.20, SD=2.36; Control: M=34.87, SD=3.20), with similar patterns observed for social competence (HCI: M=126.13, SD=5.23; EFT: M=129.27, SD=7.75; Control: M=127.70, SD=5.48). Post-intervention, both HCI and EFT groups exhibited substantial increases (help-seeking: HCI M=41.60, SD=2.69; EFT M=44.27, SD=2.71; social competence: HCI M=136.27, SD=5.10; EFT M=142.40, SD=4.33), while the control group remained stable. These outcomes persisted at follow-up, underscoring the interventions' sustained impact.

Table 3. Descriptive statistics of help-seeking behaviors and social competence scores by group and assessment phase.

Variable	Stage	HCI	EFT	Control
		Mean±SD	Mean±SD	Mean±SD
Help-seeking Behaviors	Pre-test	35.40±1.99	34.20±2.36	34.87±3.20
	Post-test	41.60±2.69	44.27±2.71	35.53±3.27
	Follow-up	42.93±2.84	45.47±2.66	36.07±3.24
Social Competence	Pre-test	126.13±5.23	129.27±7.75	127.70±5.48
	Post-test	136.27±5.10	142.40±4.33	128.20±5.43
	Follow-up	139.40±4.77	144.20±6.29	127.73±4.74

Table 4 delineates the ANOVA outcomes, revealing robust main effects for time on both help-seeking behaviors (F=413.90, P<0.001, η^2=0.80) and social competence (F=1514.22, P<0.001, η^2=0.87), alongside significant group effects (help-seeking behaviors: F=20.12, P<0.001, η^2=0.49; social competence: F=13.76, P<0.001, η^2=0.39). Critically, the group×time interactions were highly significant (help-seeking behaviors: F=86.33, P<0.001, η^2=0.70; social competence: F=333.46, P<0.001, η^2=0.84), evidencing differential intervention efficacy over time with large effect sizes.

Table 4. Repeated-measures ANOVA results for help-seeking behaviors and social competence.

Variable	Source	SS	df	MS	F	P	η^2
Help-seeking Behaviors	Time	1160.23	1.35	861.49	413.90	0.001	0.80
	Group×Time	484.03	2.69	179.70	86.33	0.001	0.70
	Group	837.39	2	418.69	20.12	0.001	0.49
Social Competence	Time	2390.71	1.48	1617.82	1514.22	0.001	0.87
	Group×Time	1052.97	2.96	356.28	333.46	0.001	0.84
	Group	2696.31	2	1348.15	13.76	0.001	0.39

Post-hoc analyses using Bonferroni-corrected pairwise comparisons (Tables 5 and 6) confirmed significant within-group improvements from pre-test to post-test and follow-up for both interventions (all P<0.001 for active groups; control non-significant). Between-group comparisons revealed that both HCI and EFT significantly outperformed the control group at post-test and follow-up on both outcomes (P<0.001). The EFT demonstrated modest but statistically significant

superiority over HCI at post-test for social competence (mean difference=6.13, P=0.015) and a trend for help-seeking behaviors (mean difference=2.67, P=0.048); however, these differences diminished at follow-up (social competence P=0.053; help-seeking behaviors P=0.067).

Table 5. Post-hoc pairwise comparisons of mean differences within groups across time points.

Variable	Time	HCI		EFT		Control	
		Mean Difference	P	Mean Difference	P	Mean Difference	P
Help-seeking Behaviors	Post-test and Pre-test	6.20	0.001	10.07	0.001	0.67	0.999
	Follow-up and Pre-test	7.53	0.001	11.27	0.001	1.20	0.948
	Follow-up and Post-test	1.33	0.472	1.20	0.633	0.53	0.999
Social Competence	Post-test and Pre-test	10.13	0.001	13.13	0.001	1.00	0.999
	Follow-up and Pre-test	13.27	0.001	14.93	0.001	0.53	0.999
	Follow-up and Post-test	3.13	0.289	1.80	0.999	0.47	0.999

Table 6. Post-hoc pairwise comparisons of mean differences between groups at each assessment phase.

Variable	Groups	Pre-test		Post-test		Follow-up	
		Mean Difference	P	Mean Difference	P	Mean Difference	P
Help-seeking Behaviors	HCI and EFT	1.20	0.625	2.67	0.048	2.53	0.067
	HCI and Control	0.53	0.999	6.07	0.001	6.87	0.001
	EFT and Control	0.67	0.999	8.73	0.001	9.40	0.001
Social Competence	HCI and EFT	3.13	0.533	6.13	0.015	4.80	0.053
	HCI and Control	1.07	0.999	8.67	0.001	11.67	0.001
	EFT and Control	2.07	0.999	14.20	0.001	16.47	0.001

Discussion

The primary objective of the present work was to compare the effectiveness of the HCI and EFT in improving help-seeking behaviors and social competence among depressed female students. The findings support the hypotheses, demonstrating that both therapeutic modalities yielded significant and lasting improvements in both dependent variables compared to the no-treatment control group.

The significant enhancement of help-seeking behaviors in both experimental groups is highly consequential, as reluctance to seek support is a hallmark of depression that impedes recovery. The efficacy of EFT in this domain is consistent with its core theoretical model, which actively encourages emotional processing and validation [17]. By transforming maladaptive emotions (such as shame or fear of judgment) into adaptive coping responses, EFT fundamentally reduces the internal barriers that inhibit reaching out [24]. This result aligns with the findings of a meta-analysis conducted by Szücs et al. [25], which confirmed that emotionally expressive and experiential therapies are highly effective in overcoming help-seeking reluctance among adolescents. The EFT's slight immediate advantage over HCI may stem from its structured, therapist-guided focus on identifying and transforming specific maladaptive emotions, facilitating faster shifts in relational and behavioral patterns, as evidenced in prior EFT trials showing rapid gains in interpersonal functioning [26].

Similarly, the success of HCI in improving help-seeking behaviors suggests that its mechanism—aimed at relieving underlying cellular and emotional stress—effectively frees up the cognitive and psychological resources necessary for proactive coping [15]. When the internal burden of depression is reduced, the threshold for initiating supportive action, like seeking help, is lowered. This effect is congruent with studies examining energy-based or somatic interventions, which link reductions in physiological distress to enhanced emotional regulation and approach behaviors [27].

The substantial and sustained gains in social competence observed in both the HCI and EFT groups underscore their utility in mitigating the relational deficits caused by depression. EFT, through its explicit focus on relational process and self-to-other emotional regulation (e.g., using empty-chair work to resolve relational unfinished business), directly addresses the impaired communication and interpersonal skills characteristic of depressed individuals. The present finding that EFT significantly boosts social competence strongly corroborates research by Greenman and Johnson [26], who reported that EFT significantly improved dyadic relational skills and decreased feelings of social isolation in clinical samples.

The simultaneous effectiveness of HCI in enhancing social competence suggests that this intervention facilitates a generalized improvement in psychological functioning. By targeting core emotional blocks, HCI may increase emotional availability and flexibility, essential preconditions for effective social interaction [13]. When students are less consumed by internal distress, they possess greater cognitive capacity to read social cues and engage appropriately, which translates into higher perceived social competence.

While both interventions were highly effective, the post hoc analysis revealed that the EFT group

achieved statistically superior immediate gains in both help-seeking behaviors and social competence compared with the HCI group. This immediate and stronger effect suggests that EFT's direct and process-directive focus on identifying, exploring, and transforming specific emotions may lead to faster acquisition of complex social and behavioral skills. However, the non-significant differences at the one-month follow-up indicate that both protocols successfully established stable, enduring therapeutic change. Clinically, this suggests that EFT may be preferable when rapid skill acquisition is paramount, while HCI offers a viable and alternative path to long-term psychosocial resilience. Several limitations should be acknowledged regarding the present study. First, the unequal number of sessions (14 for HCI versus eight for EFT) represents a potential confound, as greater treatment dosage in HCI may have contributed to its sustained effects despite EFT's faster initial gains. Second, the relatively small sample size (n=15 per group) limits statistical power and, combined with the exclusive inclusion of female high school students, restricts generalizability to male adolescents, clinical populations, or other cultural contexts. Third, reliance on self-report measures introduces the possibility of social desirability bias or response shifts due to heightened awareness from participation. Finally, HCI, as an emerging energy-based approach with limited empirical support from large-scale randomized trials, requires cautious interpretation; its theoretical basis in cellular memory and energy centers remains outside mainstream psychological frameworks.

Conclusion

It was demonstrated that both the HCI and EFT were highly effective and viable therapeutic modalities for addressing the psychosocial deficits associated with depression in adolescent students. The repeated-measures ANOVA confirmed that students in both experimental groups exhibited significant and sustained improvements in help-seeking behaviors and social competence when compared to the control group. While EFT initially demonstrated a statistically stronger effect, particularly on social competence, the one-month follow-up showed that both interventions were comparably successful in establishing durable therapeutic change. These findings advocate for the integration of both HCI and EFT protocols into school-based mental health services to enhance core coping and relational skills among depressed youth. However, future research with larger, gender-diverse samples, equal session dosages, multi-informant assessments, and longer follow-ups is needed to strengthen generalizability and further elucidate mechanisms of change.

Ethical Considerations

This research obtained formal approval from the Institutional Review Board of Islamic Azad University, Ahvaz Branch, Iran (IRB No.: IR.IAU.AHVAZ.REC.1403.504).

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Author Contributions

All authors contributed equally to the preparation of all parts of the research.

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Conflicts of Interest

The authors declare that there is no conflict of interest.

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