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Effectiveness of Psychotherapy: Synthesis of a "Meta-Analytic Research Domain" Across World Regions and 12 Mental Health Problems

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Mathias Harrer and Clara Miguel share first authorship. This study was registered with Open Science Framework at https://osf.io/ha745; open data and code have been made publicly available using Zenodo and can be accessed at https://doi.org/10.5281/zenodo.11116214. All code and data are openly available on a Github repository at https://github.com/MathiasHarrer/supersizing-meta-analysis.

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continued

The scientific output generated in psychology has surged in recent decades, including the number of studies investigating psychological treatments. To keep track of all this evidence, we developed the "Metapsy" meta-analytic research domain: a comprehensive system of open databases and tailored software that allows for rapid evidence generation. We leverage this novel infrastructure to summarize the effect of psychological treatment across 12 mental health problems and trace back the global expansion of psychotherapy research over the past 50 years. Including 1,029 studies with 85,952 patients, our results indicate small to moderate average benefits in treating psychosis ($g = 0.32$), suicidal ideation ($g = 0.34$), borderline personality disorder ($g = 0.46$), and prolonged grief ($g = 0.49$). In contrast, psychological interventions have large average effects on depression ($g = 0.73$), problem gambling ($g = 0.80$), panic ($g = 0.83$), generalized anxiety ($g = 0.86$), social anxiety ($g = 0.95$), obsessive–compulsive ($g = 1.18$), posttraumatic stress disorder ($g = 1.18$), and phobias ($g = 1.25$). Most available evidence (83.4%–86.1%) comes from high-income and Western countries, but their dominance is declining. We found no indication that psychotherapy is less effective in low- and middle-income countries ($g = 0.38$–2.41) or non-Western cultures ($g = 0.74$–2.20). We discuss ways to further enhance psychotherapy's public health impact, as well as how the meta-analytic research domain concept may be extended to other types of psychological research in the future.

Public Significance Statement

Our study summarizes the features and findings of a newly established "meta-analytic research domain" that provides up-to-date evidence on the efficacy of psychological treatments. Our results underline that psychological interventions are a suitable method to address mental health problems on a global scale. Further steps are needed to increase their dissemination and to determine "what works for whom." The system of open databases and software tools we have developed could enable practitioners to optimize mental health care decisions worldwide, by allowing suitable stakeholders to generate tailored meta-analytic evidence in a rapid and reproducible manner.

Keywords: meta-analysis, psychotherapy, mental disorders, systematic reviews, meta-analytic research domain

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Mental disorders are highly prevalent worldwide. Around one in five people are affected by them in any given year (Kessler, Aguilar-Gaxiola, et al., 2009), and one in three people are estimated to develop a mental disorder at least once in their lifetime (Chesney et al., 2014; Kessler, Aguilar-Gaxiola, et al., 2009; Steel et al., 2014; Vigo et al., 2016). Suffering from a mental disorder predicts numerous negative outcomes for the individual and society, including marginalization on the labor market (Niederkrotenthaler et al., 2014, 2016), worse educational attainment (Eisenberg et al., 2009; Hysenbegasi et al., 2005; Kessler et al., 1995), role

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functioning (Fergusson & Woodward, 2002), and somatic health (Hare et al., 2014; Wang, Li, et al., 2020), as well as early mortality (Cuijpers & Smit, 2002).

Psychotherapy can be defined as the "application of psychological mechanisms and interpersonal stances derived from psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions or other personal characteristics in directions that the participants deem desirable" (Campbell et al., 2013). In the past 50 years, a wide range of such psychological treatments have been developed and evaluated in randomized controlled trials (RCTs). Meta-analytic syntheses of these trials show that psychotherapies are effective for various mental health problems, for example, depression (Cuijpers, Miguel, Harrer, Plessen, Ciharova, Papola, et al., 2023; Cuijpers, Quero, Noma, et al., 2021); anxiety disorders, including generalized anxiety disorder (GAD; Papola, Miguel, et al., 2024), social anxiety disorder (SAD; de Ponti et al., 2024), panic disorder (Papola et al., 2022), and specific phobias (Wolitzky-Taylor et al., 2008); obsessive–compulsive disorder (OCD; Öst et al., 2015; Y. Wang et al., 2024); posttraumatic stress disorder (PTSD; Hamblen et al., 2019; Hoppen et al., 2023, 2024); borderline personality disorder (BPD; Cristea et al., 2017); psychotic disorders (i.e., schizophrenia, schizophreniform disorder, schizoaffective disorder, and delusional disorder; Bighelli et al., 2018, 2021; Mc Glanaghy et al., 2021); prolonged grief disorder (Johannsen et al., 2019); problem gambling (Pfund et al., 2023a); or suicidality (van Ballegooijen et al., 2025). Psychological treatment has also been found to be effective across various target and age groups (Cuijpers, Karyotaki, Eckshtain, et al., 2020; Cuijpers et al., 2018; Harrer et al., 2019; Miguel et al., 2023; Weitz et al., 2018), and, in many cases, such treatment is cost-effective (Belay et al., 2023; Donker et al., 2015; Ophuis et al., 2017; Ross et al., 2019).

Current evidence suggests that the benefits of psychotherapy may vary across different mental health conditions. For instance, prior meta-analyses show larger effect sizes for anxiety disorders (standardized mean difference [SMD] = 0.67–1.09; de Ponti et al., 2024; Papola et al., 2022; Papola, Miguel, et al., 2024; Wolitzky-Taylor et al., 2008) and depression (SMD = 0.39–1.10; Cuijpers, Miguel, Harrer, Plessen, Ciharova, Papola, et al., 2023), but smaller benefits for disorders like BPD (SMD = 0.32; Cristea et al., 2017) and psychosis (SMD = 0.29; Bighelli et al., 2018). However, these effect estimates are difficult to compare directly due to a lack of meta-analytic studies that assess the benefits of psychological treatments across different indications using a consistent methodology. Effect estimates also often depend on the chosen control group: There is, for example, substantial evidence that wait-list controls may overestimate psychological treatment effects compared to care-as-usual conditions (Cuijpers, Miguel, Harrer, Ebert & Karyotaki, 2024; Furukawa et al., 2014). This makes it more difficult to compare psychotherapy effects in different trials and across indications.

Psychotherapy research is a multifaceted field, encompassing a broad variety of research traditions and treatment approaches (Wampold & Imel, 2015). Psychotherapeutic formats frequently differ in their underlying theory, case conceptualization, applied techniques, and modality, even when targeting the same indication. One of the most well-researched treatment formats is cognitive behavioral therapy (CBT), which emphasizes the connection between dysfunctional thoughts, behaviors, and emotions in the treatment of mental disorders (Beck & Fleming, 2021). There is substantial meta-analytic evidence supporting the effectiveness of CBT-type therapies for various indications, including depression, anxiety disorders, PTSD, and OCD (Cuijpers, Miguel, Ciharova, et al., 2024). CBT itself is not a homogeneous treatment format and encompasses many (often disorder-specific) adaptations, such as trauma-focused CBT for PTSD (Schnurr, 2017), dialectic behavioral therapy for BPD (Robins & Chapman, 2004), or "third-wave" CBT approaches (Hayes & Hofmann, 2017). Another common format is psychodynamic therapies, whose foundations date back to the works of Freud, Adler, and Jung (Ellenberger, 1994, Chapters 7–9). Meta-analytic evidence also supports the efficacy of psychodynamic therapy, for example, in treating depression (Wienicke et al., 2023) and personality disorders (Keefe et al., 2020). Interpersonal therapy is another format with a solid evidence base, including meta-analytic studies, for various mental disorders (Cuijpers, Miguel, Harrer, Ebert, & Karyotaki, 2024; Weissman & Mootz, 2024, Chapter 2). Originally developed for depression, interpersonal therapy puts a strong emphasis on social relationships in the treatment of mental disorders (Markowitz & Weissman, 2004). Another exemplary treatment format is nondirective supportive therapy (NDST). NDST is rooted in the client-centered tradition in psychotherapy, often associated with the work of Rogers (1975). Such therapies assume that relief from personal problems can be achieved by offering empathy, positive regard, and discussion with others (Cuijpers, Karyotaki, de Wit, et al., 2020). In RCTs, NDST is often used as a comparator treatment without any "specific" therapeutic ingredients. However, meta-analytic evidence shows that NDST alone can be an effective treatment as well, for example, for depression, although its average effects are often lower (Cuijpers, Miguel, Harrer, Ciharova, et al., 2024). A multitude of other therapeutic formats could be added here, many of which are supported by randomized controlled evidence. For depression alone, Cuijpers, Karyotaki, de Wit, et al. (2020) reported positive meta-analytic findings for more than a dozen therapy types.

In the past 2 decades, psychotherapy research has also increasingly focused on the modalities through which treatments can be delivered. For instance, there are now many meta-analyses showing that digital psychological interventions can be effective for various mental disorders (Andersson, 2016; Andersson & Titov, 2014). Another innovation is task-sharing interventions, in which specific treatment components are redistributed to less specialized health care workers in the community (Hoeft et al., 2018; Karyotaki et al., 2022). Such formats may be particularly helpful in low-resource settings, in which trained mental health professionals are scarce. Group therapy is another method to deliver treatment to a larger number of patients. Group-based interventions have a long-standing tradition in psychotherapy, both in research and practice, and have been shown to be effective for various indications (Barkowski et al., 2020; Huntley et al., 2012; Jónsson & Hougaard, 2009; Koffel et al., 2015; Lo Coco et al., 2019; Schwartze et al., 2019; Wersebe et al., 2013).

At its inception, psychotherapy research was conducted almost exclusively in high-income Western countries. All major psychotherapeutic formats originate from these countries. This historic legacy could be problematic for several reasons. First, it probably means that most published psychotherapy research was conducted in resource-rich Western countries, even though more than 80% of all patients with mental disorders live in low- and middle-income countries (LMICs; Rathod et al., 2017). Second, it means that most psychological treatments have been developed in a specifically "Western"

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sociocultural setting. Prominent theories of psychotherapy emphasize that contextual factors play an important role in psychological treatment (Wampold, 2017). Therefore, it is possible that the benefits of psychotherapy differ if it is delivered in other cultural contexts or in low-resource settings. The World Health Organization's (2022) Mental Health Gap Action Programme guideline for mental, neurological, and substance use disorders (Brohan et al., 2024) contains a strong recommendation to implement psychological interventions for six mental disorders groups but emphasizes the need for more evidence in LMICs for many indications.

While psychotherapy research has historically focused on high-income, Western countries, this is rapidly changing. Today, psychological treatments are examined all around the world, and, for conditions like depression, we know that the share of trials conducted in the Middle East, sub-Saharan Africa, and Latin America is strongly increasing (Cuijpers et al., 2018; Tong et al., 2023). Meta-analyses of this growing body of evidence indicate that psychotherapies are also effective outside of high-income Western countries, for example, for depression and anxiety disorders (Barbui et al., 2020; Cuijpers et al., 2018; Tong et al., 2023), or for PTSD (Morina et al., 2017). However, no analysis has yet examined the proliferation of psychotherapy research in LMICs and non-Western regions systematically across conditions. The globalization of psychotherapy research also manifests itself in a sharp increase in the total number of trial publications overall. For depression, less than 20 RCTs were published until 1985, compared to the more than 550 trials available today, and that number keeps increasing every year (Cuijpers, Harrer, et al., 2023).

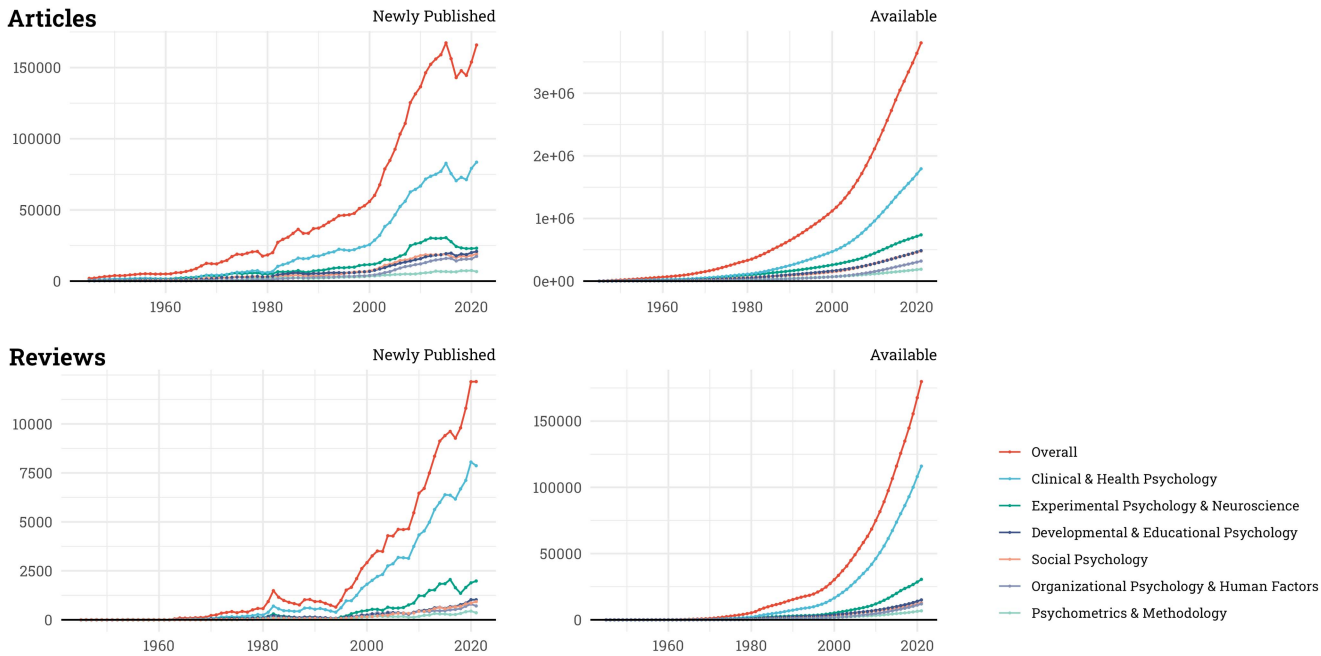
To keep track of all the evidence in psychotherapy research, comprehensive studies across the entire research domain are needed. Such large-scale syntheses would allow to examine broader research trends, such as the expansion of psychotherapy research across different world regions, and they could summarize treatment effects for different indications, treatment formats, and comparators using a standardized methodology. Syntheses of such an enormous scale have previously been very challenging but have now been greatly facilitated by a "meta-analytic research domain" (MARD) we have developed for this purpose. In the following, we therefore provide an introduction to the MARD concept we leverage for the present study and the challenges in existing forms of evidence synthesis it helps to overcome.

The Rapid Growth of Psychological Research

The MARD concept was developed to address the surge in published psychological research over the past 2 decades. In the top-left panel of Figure 1, we display the yearly number of peer-reviewed articles included in APA PsycInfo, the most comprehensive indexing database in psychology. The graph shows a tremendous growth in scientific output since the middle of the 20th century, with an exponential increase from 2000 onward. Since 2015, the numbers have stabilized around roughly 150,000 peer-reviewed reports per year. Similar trends are found in all major subfields. Research on psychological treatments falls within clinical and health psychology, which alone accounts for nearly half of the total scientific output. The top-right panel shows what these numbers mean for the available literature in psychological research.

Figure 1

Peer-Reviewed Articles and Reviews Indexed in APA PsycInfo, 1945–2021



Note. Hits were restricted to peer-reviewed journal articles. The search strategy used to obtain these data is presented in the Supplemental Material S1. "Newly published" refers to the number of articles published in a given year. The "available" panels show the cumulative sum of indexed articles at each year. e = Exponent. See the online article for the color version of this figure.

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It is clear from these graphs that psychologists in the 21st century are confronted with a gigantic and ever-increasing body of evidence. This deluge of scientific output makes it difficult even for seasoned researchers to keep track of all available evidence, let alone draw sound conclusions from it. Evidence synthesis has therefore become indispensable in psychology, particularly in the form of *systematic reviews.* These reviews are frequently supplemented by a quantitative synthesis, better known as *meta-analysis* (Harrer et al., 2021; Schmid et al., 2021).

Systemic Issues in Meta-Analytic Research

Systematic reviews and meta-analyses are a dominant design in psychological research; as of 2023, APA PsycInfo lists more than 170,000 peer-reviewed items with one of those names in the title. This publication type is particularly common in clinical and health psychology, which makes up more than two thirds of the total publication volume (115,000 items). Looking at the bottom-right panel in Figure 1, we also see that reviews are not only common but also are now accumulating faster than psychological research in general. To some extent, such a disproportionate rise in reviews may be expected as the volume of published findings grows. Nevertheless, there is a risk that evidence synthesis increasingly falls prey to its own success. Confronted with a deluge of overlapping (Siontis et al., 2013) and at times conflicting (Ioannidis, 2016) reviews, making sense out of the available evidence is again becoming more and more difficult. This development corrupts the original purpose of evidence syntheses.

Meta-epidemiological studies also show that the methodological quality of systematic reviews and meta-analyses remains highly inconsistent (Page et al., 2018; Uttley et al., 2023), burdening readers with the additional task of differentiating between "good" and "bad" reviews. Policymakers and senior managers have frequently remarked on how difficult it is to navigate and assess available research syntheses, thus deepening the gap in knowledge translation (Grimshaw et al., 2012). In their present state, many reviews and meta-analyses may contribute to the production of research waste rather than reduce it (Bastian et al., 2010; Lund et al., 2016; Roberts & Ker, 2015; Uttley et al., 2023).

Meta-Analytic Research Domains

Taking a step back, we see that the expansion of psychotherapy research is part of a much greater development, in which scientific production in psychology as a whole is accelerating worldwide. This system crucially depends on evidence syntheses, the existing forms of which are struggling with the enormous influx of published research. The deficiencies we described above may be particularly troubling for psychological treatment research: With meta-analytic evidence being a primary source to inform treatment guidelines for mental disorders, outdated, fragmented, or misleading reviews can have a deleterious effect on patient care all around the world.

Various methodological innovations have been developed in recent years to meet these challenges. One example is *umbrella reviews* (Fusar-Poli & Radua, 2018; Papatheodorou, 2019; also known as *overviews of reviews* or *metareviews*). These are reviews that use transparent criteria to select and interpret all available syntheses on a research topic. A related innovation is *multiverse meta-analyses*, in which researchers conduct all plausible meta-analyses for a research question (see, e.g., Plessen et al., 2023). *Evidence mapping* emerged as another technique that explicitly tries to identify evidence gaps that are not covered by previous reviews (Miake-Lye et al., 2016). Evidence maps are often presented in an accessible format, for example, using visualizations or searchable databases (Haddaway et al., 2019; James et al., 2016). *Living systematic reviews* are another noteworthy innovation. This approach addresses the problem that published reviews soon become obsolete as novel research findings accumulate. For instance, it has been estimated that 7% of systematic reviews in biomedicine are already inaccurate by the time they are published and 23% after 2 years (Shojania et al., 2007). Living systematic reviews share all the main components of their traditional counterparts but are continuously updated to incorporate new evidence (Elliott et al., 2017).

Recently, we proposed MARDs (Cuijpers, Miguel, et al., 2022; Cuijpers, Miguel, Harrer, Plessen, Ciharova, Papola, et al., 2023) as a higher level of research aggregation, combining many unique strengths of these individual methods. Like living systematic reviews, MARDs are regularly updated to present up-to-date evidence, but they provide a comprehensive collection of standardized databases that extend beyond a specific population, intervention, comparator, or outcome. Like umbrella reviews, MARDs can provide a bird's-eye view of an entire research field. Similar to evidence maps, they are supplemented by tailored free and open-source software (Fortunato & Galassi, 2021) that enhances their accessibility and reusability for various stakeholders. Finally, due to their unified methodology, MARDs allow researchers to run all plausible meta-analyses to explore conflicting evidence and identify research gaps, facilitating the application of methods like multiverse meta-analyses.

An illustration of this concept is provided in Figure 2. As shown in the visualization, MARDs occupy their own position in the evidence pyramid above systematic and umbrella reviews. Their key feature lies in curating a comprehensive set of databases for an entire research domain. This standardized approach enables the consistent application of methodology and the provision of research data in an interoperable format. MARDs also promote open science practices by providing centralized documentation for all databases and their underlying research methods. Using frequent updates, MARDs provide up-to-date information for the covered evidence base. To overcome the knowledge transfer gap, they encompass software tools that allow for rapid evidence generation by various stakeholders.

MARDs may be particularly promising for psychological treatment research, where actionable, up-to-date evidence needs to be drawn from an ever-increasing number of published trials. The Metapsy initiative (https://www.metapsy.org; Cuijpers, Miguel, et al., 2022; Cuijpers, Miguel, Harrer, Plessen, Ciharova, Papola, et al., 2023) exemplifies this approach, providing access to comprehensive meta-analytic data of psychological interventions across relevant disorders, settings, and populations. Our MARD project currently harmonizes living databases curated by more than a dozen university-based research groups and government agencies (e.g., the National Center for PTSD in the U.S. Department of Veterans Affairs and the Dutch organization for suicide prevention).

The Present Study

Collectively, the Metapsy databases compile an unprecedented amount of data on the effectiveness of psychological treatment. In the following sections, we use this information to synthesize the benefits of psychological interventions across 12 mental health

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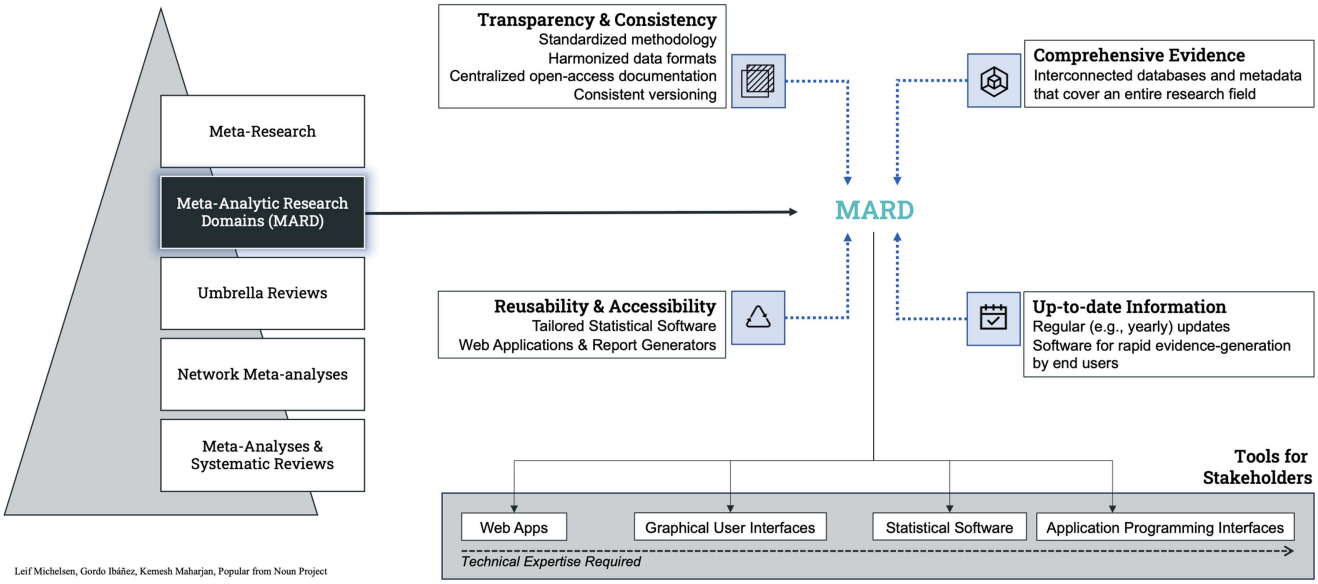
Figure 2

Features of Meta-Analytic Research Domains



Note. See the online article for the color version of this figure.

problems (depression, GAD, SAD, panic disorder, specific phobias, OCD, PTSD, BPD, psychosis, prolonged grief, problem gambling, and suicidal ideation). Using a unified methodology, we will (a) present the average meta-analytic effects of psychotherapy for all included indications; (b) summarize the existing evidence for all major treatment formats, taking into account the impact of different comparators (i.e., care-as-usual vs. wait-lists); (c) analyze the accumulation of evidence from non-Western countries and LMICs over the past 50 years; and (d) examine the effectiveness of psychological treatments outside the high-resource Western regions in which they were originally developed. Finally, we also provide some further information on the openly accessible infrastructure of the Metapsy MARD and how different stakeholders can use it.

Method

The Metapsy Infrastructure

All data we synthesize in this meta-analytic review come from living databases that have been integrated into the Metapsy MARD. The following sections outline the main components of this novel infrastructure, detail the methods used for data collection and harmonization, and present specialized software developed for the project. This also includes tailor-made statistical tools that were used for the present meta-analysis.

Databases

The centerpiece of the Metapsy MARD is a comprehensive database on psychotherapies for depression that has been developed over the past 15 years (Cuijpers et al., 2008; Cuijpers, Miguel, Harrer, Plessen, Ciharova, Papola, et al., 2023). This database has been used for various meta-analytic studies within the past decade (Cuijpers, 2017; Cuijpers, Miguel, Harrer, Plessen, Ciharova, Papola, et al., 2023). The database currently includes the results of 868 individual randomized clinical trials and is updated three times per year. Because the depression database serves as the "boilerplate" for all other indications included in Metapsy, we describe its methodology in greater detail here. A comprehensive description of the database methodology is presented by Cuijpers, Karyotaki, Ciharova, et al. (2019).

Novel studies in the depression database are identified by searching four major bibliographical databases (Pubmed, APA PsycInfo, Embase, and the Cochrane Library) from 1966 onward. The search strings combine index terms and text words indicative of depression and psychotherapies, with filters for RCTs. Records that are retrieved by these searches are screened by two independent researchers. All reports that could possibly meet the inclusion criteria are then retrieved as full text. Based on the retrieved full text, the two researchers independently decide to include or exclude the study in the database, and disagreements are resolved through discussion. To be eligible for the database, a study has to be (a) an RCT that compares (b) any psychological depression intervention (c) for any age or target group with (d) any comparison group. Only trials published in peer-reviewed journals are considered. "Gray literature" (i.e., dissertations or other publications without formal peer-review) was considered in previous versions, but it is excluded in the latest versions of the database (Cuijpers & Karyotaki, 2019) and in all Metapsy data sets that were modeled after the depression database in recent years. Psychological interventions are defined as "the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable" (Campbell et al., 2013). This definition is interpreted broadly and also encompasses unguided self-help interventions, digital therapeutics, or experimental

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"bottom-up" therapies (Cristea et al., 2021) such as cognitive bias modification. Any comparator is allowed, including "prototypical" control conditions (wait-list, usual care, pill placebo, etc.), other psychotherapies, pharmacotherapy, combined treatment, and other comparators for which only a limited number of trials are available (e.g., bright light therapy or exercise).

The data extraction is also conducted by two independent researchers. For each study, five categories of data are extracted: (a) characteristics of the participants in the study; (b) characteristics of the interventions; (c) general characteristics of the study; (d) risk of bias information; and (e) data to calculate effect sizes. Participant characteristics extracted at the study level include the type of diagnosis, recruitment method, target and age group, mean age, percentage of women, and presence of comorbid mental disorders. Characteristics of the intervention are extracted at the level of the treatment arm (because some studies contain multiple active arms). Psychological treatments are categorized based on a taxonomy originally developed in Cuijpers et al. (2008), with a recent update by Cuijpers and Karyotaki (2019). An overview of the taxonomy is provided in Supplemental Material S2. Furthermore, the number of sessions is extracted. General study characteristics include the country of origin, year of publication, recruitment method, target group, and the method by which diagnoses were obtained. The risk of bias (RoB) in each study is assessed using four criteria of the RoB tool (Higgins et al., 2011). Currently, Version 1 of the tool is used because the database was created over 15 years ago. A newer version (RoB 2) has since been developed, but its developers have indicated that moving to this version may not be required for updates of older databases (Sterne et al., 2019). In recent updates, new trials have been additionally rated using the RoB 2 tool, and a rerating of older trials is planned within the coming years. Currently, the four RoB items included in the database evaluate potential biases due to inadequate generation of the allocation sequence, as well as bias associated with allocation concealment, the masking of assessors, and the strategy used to handle missing data. The last criterion is assessed as positive (i.e., low risk of bias) when intention-to-treat analyses were conducted, meaning that all randomized participants were subsequently analyzed. Other criteria such as selective outcome reporting have been examined in specific meta-analyses (Miguel et al., 2021) and will be systematically included in the database as we move toward the RoB 2 assessments. Overall, studies are considered to show a low risk of bias when they score low on all four assessed criteria.

Results of all reported depression symptom instruments are extracted from each trial. A prespecified hierarchy is used when extracting the effect size data, which gives priority to the raw mean, standard deviation, and sample size of each condition at all assessed time points. The means and standard deviations at posttest can be used to directly calculate the small-sample bias-corrected standardized mean difference (i.e., Hedges's g) and its sampling variance. If this information is not reported, change scores are extracted instead. Endpoint means are prioritized over change scores because the latter requires knowledge of the pre–post correlation in the trial, and this information is rarely reported (Cuijpers et al., 2017). Despite widespread belief, change scores typically do not allow to adjust for patients' baseline symptom severity (Clifton & Clifton, 2019). When necessary, change score effect sizes are calculated assuming a pre- and posttest score correlation of $r = 0.5$, which is within the typical range for psychiatry trials and minimizes the divergence compared to endpoint SMDs (Balk et al., 2012; Harrer, Miguel, et al., 2024). If change scores are unavailable, we extract binary outcomes, such as the proportion of participants who responded, remitted, or no longer met criteria for a depressive disorder after treatment. This information can be converted to Hedges's g assuming, for example, a logistic distribution (Chinn, 2000). If no binary outcome data are reported, we use any other statistic indicating the difference between the two conditions at posttest that can be transformed to an effect size (such as T and χ^2 values or regression coefficients; Harrer et al., 2021, Chapter 17). Overall, the results of intention-to-treat analyses are prioritized. Long-term effect size data (>6 months since randomization) are also extracted if available. All effect sizes are calculated using functions of the *metapsyTools* package, which was developed specifically for the Metapsy initiative (Harrer et al., 2022). Exact formulas used to obtain outcome measures and their sampling variance within the package are presented in Supplemental Material S3.

Once the data extraction has been completed, studies are bundled into "scientific use files" (SUFs; Gollwitzer et al., 2021), which are smaller data sets that focus on a specific type of comparator. The largest of these SUF data sets contains trials comparing psychological treatments with control conditions (wait-list, care-as-usual, and other controls such as pill placebo or attention placebo). Another data set is for trials that compare psychological interventions to pharmacotherapy and combined treatments. A third SUF includes trials with head-to-head comparisons of different psychological treatments. Finally, there is a range of smaller data sets that focus on special interest topics (e.g., psychological interventions for children and adolescents, treatments in inpatient settings, unguided digital therapeutics, novel and experimental treatments, dismantling and component studies).

The depression database serves as a template for a range of other databases that have been integrated into the Metapsy infrastructure recently. All of these databases follow the same core steps of the depression database, although some aspects of the study search, data extraction, and rating necessarily differ. These new databases cover a broad range of indications, including anxiety disorders, suicidal thoughts and behaviors, PTSD, mental health problems in children and adolescents, psychotic disorders, problem gambling, OCD, complicated grief, and BPD and have been employed in various indication-specific meta-analyses in the past (anxiety disorders: de Ponti et al., 2024; Papola et al., 2022, 2023; Papola, Miguel, et al., 2024; suicidality: van Ballegooijen et al., 2025; PTSD: Cuijpers, Miguel, Harrer, Ciharova, et al., 2024; children and adolescents: Cuijpers, Karyotaki, et al., 2023; psychotic disorders: Mc Glanaghy et al., 2021; OCD: Y. Wang et al., 2024; problem gambling: Pfund et al., 2023a; complicated grief: Quero et al., 2019; BPD: Cristea et al., 2017).

More information on the compilation and maintenance of the Metapsy databases can be found in the Supplemental Material. In Supplemental Material S4, we describe a uniform "data standard" that is enforced to harmonize information across all databases and make them interoperable. Supplemental Material S5 details the dedicated workflow through which SUFs are versioned and publicly released. In Supplemental Material S6, we provide a flowchart summarizing all steps required to develop, release, and maintain a Metapsy database.

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Documentation

The Metapsy initiative features a searchable online documentation at https://docs.metapsy.org. The documentation is organized in six blocks that describe (a) the background, motivation, and collaborators of the Metapsy initiative; (b) existing data sets that are available to the public; (c) the methodology used to prepare the data; (d) the data release workflow; (e) the R Packages and application programming interface (API) developed for the project; and (f) the graphical user interface- (GUI-) based meta-analysis tools hosted on the website.

In the database block (https://docs.metapsy.org/databases), each SUF (i.e., released data set) is provided with its unique documentation entry. In their first section, entries include a general description of the populations, interventions, comparators, and outcomes included in the data set, as well as some basic information on the applied methodology. The documentation also displays all relevant metadata: the number of included studies, the latest version number and versioned history of the data set, the dates of the last search and the last release, the exact search strings used for different bibliographical databases, a link to the associated data repository and preregistration file, as well as the DOI assigned to the data set. This section also specifies the license under which a data set is shared. By default, an Open Data Commons Attribution (Miller et al., 2008) license is used, which means that everyone is free to share, distribute, modify, transform, and/or build upon the database, provided that the original data set is referenced. Other presented information includes a description of each variable, the full references for all studies, and a Preferred Reporting Items for Systematic Reviews and Meta-Analyses diagram detailing the search and study inclusion flow. At the end of each entry, users can download the current and each previous versions of the data set as a CSV file.

Documentation entries are automatically generated by sourcing data files and metadata indexed in Zenodo, an all-purpose open repository operated by the European Organization for Nuclear Research. This ensures that the documentation always reflects the latest stage of a data set. Documentation is also available for each previous state of a data set, and these older versions can be downloaded as well to ensure that previous findings remain reproducible.

Research Software and Graphical User Interfaces

In the past decade, there has been a push to improve the reproducibility of psychological research by making research materials, analysis data, and code publicly available (Hardwicke et al., 2022). In systematic reviews and meta-analyses, such open science practices remain heavily underused. A recent metareview found that only 11% of the examined meta-analyses in psychological research included additional data required to reproduce the analyses, and only 1% provided statistical code (Polanin et al., 2020). López-Nicolás et al. (2022) reported slightly better results for meta-analyses of psychological interventions. However, they also found that the vast majority of data are not shared in an interoperable format, namely, in a way that allows researchers to easily reuse the shared data using open-source statistical software. These findings underline that sharing open material alone is not enough: The data also needs to be provided in a format that can be easily accessed and reproduced by others within a programming environment (Lindsay, 2023).

The Metapsy initiative aims to address this gap by maintaining *metapsyData* (https://data.metapsy.org), an open-source package that allows users to download all available data sets directly into an R environment. Data sets imported by the metapsyData package can be directly analyzed with R, using base R or any R extension of choice. A recommended option is the metapsyTools package, which has been specifically developed for this purpose. In its analysis module (https://tools.metapsy.org/analysis), metapsyTools contains a suite of tailored functions that perform various meta-analysis models and sensitivity analyses. The module can be used "out-of-the-box" and with minimal coding effort, provided that the analyzed data conform to the Metapsy data standard. Conformity is guaranteed when the data have been imported using metapsyData.

Technical details on the two R packages are provided in Supplemental Material S10. This section also provides a table with all meta-analytic models, sensitivity, and publication bias analyses that are run simultaneously using metapsyTools, with further information available on its designated documentation page (https://tools.metapsy.org/get-started). In Supplemental Material S10, we also introduce an API (https://www.metapsy.org/api) maintained by the Metapsy initiative, which can be used to import data in a machine-readable format from any programming language and allows to develop new software based on the databases.

The Metapsy R packages and API are geared toward researchers with programming skills. To facilitate evidence generation for a larger audience, Metapsy additionally provides a suite of broadly accessible GUIs. An online meta-analysis tool has been developed for most data sets, and these applications can be opened through the homepage of the project (https://metapsy.org/databases). The tools run on the latest released version of a data set, which can be filtered further using buttons and sliders to answer specific research questions. This allows, for example, the examination of effects from studies published after a certain year, targeting specific interventions or population groups, or restricting results to low-risk-of-bias evidence. The tool then automatically applies several meta-analytic methods to the selected data and displays the results graphically. After inspecting the results, it is possible to generate a PDF report that summarizes the obtained results. The data of the analysis are appended to this report and assigned with a unique tracking ID. All applied filters are also documented, which can be used by others to confirm that findings are not merely the result of "torturing" the available selectors. In the appendix, the report displays the references of all included studies, as well as a technical summary of the R and package versions that were used to run the analyses. Two example reports can be viewed in Supplemental Material S8. For patients and clinicians, the Metapsy initiative also provides a meta-analytic "effect explorer" (https://metapsy.org/database/explore; Cuijpers, Miguel, Ciharova, et al., 2023; see Supplemental Material S9). This application allows users to examine the response rates of various psychological treatments for eight mental disorders; it has a minimalistic design and describes the meta-analytic results in lay language. A complete overview of available software tools for the Metapsy databases and how different stakeholders can use them is provided in Supplemental Material S7 and Supplemental Material S10.

Present Meta-Analysis

The previous sections outline the Metapsy infrastructure to highlight how its various components can benefit different target

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groups. For this study, we employed this infrastructure ourselves to conduct a comprehensive meta-analysis on the effects of psychological treatment. We focused on 12 mental health problems: unipolar depression, panic disorder, SAD, GAD, specific phobias, PTSD, OCD, BPD, prolonged grief disorder, problem gambling, psychotic disorders (including schizophrenia/psychosis, schizophreniform disorder, schizoaffective disorder, delusional disorder), and suicidality. Methodological details for all of these databases are provided in the respective documentation entries (Cuijpers, Miguel, Harrer, Plessen, Ciharova, Ebert, & Karyotaki, 2023; Mc Glanaghy et al., 2023; Papola, 2023a, 2023b; Pfund et al., 2023b; Setkowski et al., 2023b; van Ballegooijen et al., 2023). For most data sets, the date of the last search was January 1, 2023. A more recent search was used for suicide prevention (April 1, 2023), whereas only older updates were available for gambling (July 1, 2022), psychosis (January 1, 2017), and prolonged grief (July 12, 2022).

To make the results more comparable, all databases were filtered by applying the same eligibility criteria. Included were RCTs that (a) focused on adults (defined as individuals who are at least 18 years old); (b) delivered psychological treatments in an individual, group, telephone, or guided self-help format; (c) compared the treatment to an inactive control group (i.e., wait-list, attention control, care-as-usual, psychological placebo, pill placebo, other inactive controls); and (d) only considered outcomes at posttest. We did not analyze head-to-head comparisons of *bona fide* psychological treatments. These studies merit a meta-analysis of their own, which may be better addressed using a network meta-analytic approach (see, e.g., Papola, Miguel, et al., 2024). We excluded unguided self-help interventions (e.g., bibliotherapy or unguided digital therapeutics). Unguided treatments are more relevant for some disorders than others, and they are often considerably less effective than interventions that provide human support (Domhardt et al., 2019; Moshe et al., 2021; Papola et al., 2023; Schueller et al., 2017). Other existing Metapsy databases (e.g., comparisons with pharmacotherapy or dismantling studies) were not considered for inclusion in this analysis.

For all mental health problems, the pooled effect measure was the small-sample bias-corrected standardized mean difference between the intervention and control group at posttest (Hedges' g). We only used effect sizes derived from validated symptom inventories for the analyzed indication. Both self-report and clinician-rated instruments were allowed. For GAD, we included outcomes on generalized anxiety and worrying. For panic disorder, we also permitted changes in the frequency of panic attacks and subscales on agoraphobia. Problem gambling outcomes included gambling severity, duration, frequency, and intensity. For phobias, we prioritized outcomes on specific symptoms targeted by the intervention (e.g., spider fear, dental anxiety, acrophobia); more general measures (i.e., behavioral avoidance, anxiety sensitivity, state anxiety) were included if such outcomes were not available. Clinicians and self-report instruments for borderline personality disorder symptoms were considered for BPD treatments. For psychosis interventions, effects on positive, negative, and total symptoms were pooled. For suicide interventions, suicidal ideation outcomes were pooled.

In all included databases, the risk of bias assessment was conducted with the Cochrane RoB tool. Two independent researchers were used, and disagreements were resolved through discussion with a third author. The version of the tool used differed between mental health problems: The depression and gambling databases used the first version of the RoB tool, whereas RoB 2 was used in all other databases. The application of the tools varied slightly between indications to address the peculiarities of the respective research field (see Table 1 for details). We also extracted and analyzed several trial characteristics from each data set: the mean age of the participants, the proportion of females, trial recruitment, type of psychological treatment, intervention format, number of sessions, and geographical region. All analyses were conducted with the metapsyTools package, using the "runMetaAnalysis," "correctPublicationBias," and "metaRegression" functions. We used R Version 4.1.2 for all analyses.

Pooled Effects of Psychological Treatment

The correlated and hierarchical effects model was used as the main pooling model in all analyses (Pustejovsky & Tipton, 2022). We assumed a constant sampling correlation of $\rho = 0.6$ for multiple effect sizes within studies and applied cluster-robust variance estimation for the pooled effect (cluster-robust 2 estimator; see "threemodel" sections in Supplemental Table S10). After fitting the models, profile likelihood plots were inspected to check if the heterogeneity variance components were identifiable. As a sensitivity analysis, we also ran a univariate meta-analysis in which effect sizes were preaggregated before pooling ("combined" model; assuming $\rho = 0.6$), and we recalculated the results when outliers and influential studies were removed from the model. Furthermore, we calculated the results when only the highest and lowest effect size in a study was considered and when only studies with a low risk of bias were included.

Finally, we applied the trim-and-fill method, Rücker's limit meta-analysis, and a step-function selection model to control for selective publication and/or small-study effects (see Supplemental Tables S10 for further details). These methods are implemented by default within the metapsyTools package. We employed a total of three publication bias approaches because statistical methods typically have to make strong assumptions on how selective publication biased the results of a meta-analysis (Carter et al., 2019; Copas & Shi, 2000; Mathur & VanderWeele, 2020) and because simulation studies indicate that there is no "gold standard" that will provide an optimal adjustment under all circumstances (Carter et al., 2019). The "limit meta-analysis" approach we applied assumes that bias occurs primarily through small-study effects, for which it tries to adjust (Rücker et al., 2011). The "trim-and-fill" approach operates under a similar logic, but it has received criticism in the past decade (Simonsohn et al., 2014a, 2014b). Trim-and-fill method was included in this study mostly for reference given its widespread use in previous meta-analytic literature. Selection models assume that bias primarily operates based on p values. Using predefined selection thresholds, these models estimate differential inclusion likelihoods (e.g., for studies reporting "nonsignificant" effects), based on which the pooled effect is adjusted (Hedges, 1992). In our analysis, inclusion likelihoods in the selection model were estimated using one cut point at the conventional significance threshold ($p = .05$), leading to a "three-parameter selection model" (McShane et al., 2016). All of these approaches were applied to the combined model.

Numbers needed to treat (NNTs) were derived using the formula by Furukawa and Leucht (2011), with control group event rate estimates taken from a recent meta-analysis of response rates within the Metapsy databases (Cuijpers, Miguel, Ciharova, et al., 2023). Using the combined model, we also conducted subgroup-specific analyses, synthesizing the effects of specific treatments within a database. Effects were pooled separately for care-as-usual conditions

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Table 1
Study and Search Characteristics

Characteristic	Depression	Panic	SAD	GAD	Phobia	PTSD	OCD	BPD	Grief[a]	Gambling[a]	Psychosis[a]	Suicidality
Study search[b]												
Identified records	33,039	19,535	19,535	19,535	19,535	35,664	11,193	11,827	2,056	5,409	21,856	15,006
After removal duplicates	23,243	13,328	13,328	13,328	13,328	14,369	7,752	5,867	1,108	2,469	21,082	7,980
Full-texts assessed	3,987	1,378	1,378	1,378	1,378	2,138	576	228	204	70	1,328	1,131
Included studies												
Total number of studies	460	64	61	45	37	102	32	27	29	26	68	78
Total number of comparisons	560	88	85	62	61	125	36	27	32	34	75	84
Included patients												
Total number of patients	43,771	4,341	3,934	3,750	1,249	6,620	1,666	1,396	3,531	1,973	7,147	6,574
Number of patients in therapy	22,422	2,309	2,332	2,144	685	3,598	878	719	1,770	965	3,771	3,404
Number of patients in control	21,349	2,032	1,602	1,606	564	3,022	788	677	1,761	1,008	3,376	3,170
Study characteristics												
Clinical recruitment; *n* (%)	106 (23.0%)	23 (35.9%)	7 (11.5%)	19 (42.2%)	2 (5.4%)	25 (24.5%)	10 (31.3%)	24 (88.9%)	14 (48.3%)	[c]	58 (85.3%)	47 (60.3%)
M_{age} (*M*, *SD*)	43.6 (14.3)	37.3 (5.2)	33.9 (5.8)	41.7 (11.4)	32.4 (8.9)	38.9 (8.2)	34.0 (3.9)	31.8 (5.4)	46.6 (15.3)	41.8 (6.9)	36.1 (5.7)	33.2 (9.4)
Proportion women (*M*, *SD*)	0.72 (0.21)	0.69 (0.11)	0.56 (0.11)	0.71 (0.13)	0.75 (0.15)	0.58 (0.34)	0.55 (0.20)	0.82 (0.14)	0.72 (0.21)	0.41 (0.23)	0.38 (0.15)	0.61 (0.26)
Type of control; *n* (%)												
Wait-list	157 (34.1%)	41 (64.1%)	51 (83.6%)	32 (71.1%)	30 (81.1%)	67 (65.7%)	15 (46.9%)	0 (0%)	14 (48.3%)	18 (69.2%)	0 (0%)	16 (20.5%)
Care-as-usual	220 (47.7%)	13 (20.4%)	4 (6.6%)	9 (20.0%)	1 (2.7%)	18 (17.6%)	4 (12.5%)	27 (100%)	7 (24.1%)	5 (19.2%)	68 (100%)	50 (64.0%)
Country; *n* (%)												
North America	155 (33.7%)	32 (50.0%)	23 (37.7%)	18 (40.0%)	18 (48.7%)	53 (51.9%)	12 (37.5%)	9 (33.3%)	10 (34.5%)	15 (57.7%)	12 (17.7%)	30 (38.5%)
Europe	166 (36.1%)	25 (39.1%)	25 (41.0%)	16 (35.6%)	16 (43.2%)	26 (25.5%)	8 (25.0%)	16 (59.3%)	16 (55.2%)	3 (11.5%)	34 (50%)	22 (28.2%)
Other	139 (30.2%)	7 (10.9%)	13 (21.3%)	11 (24.4%)	3 (8.1%)	23 (22.6%)	12 (37.5%)	2 (7.4%)	3 (10.3%)	8 (30.8%)	22 (32.3%)	26 (33.3%)
Risk of bias												
Low risk of bias; *n* (%)	166 (36.1%)	5 (7.8%)	4 (6.6%)	8 (17.8%)	3 (8.1%)	23 (28.4%)	4 (12.5%)	3 (11.1%)	13 (44.8%)	3 (11.5%)	13 (19.1%)	2 (2.6%)
Definition (version)	Low risk for four core items (v1)	Overall low RoB (v2)	Overall low RoB (v2)	Overall low RoB (v2)	Overall low RoB (v2)	Overall low RoB (v2)	Overall low RoB or some concerns (v2)	Overall low RoB or some concerns (v2)	Overall low RoB (v2)	Low risk for four core items (v1)	Overall low RoB (v2)	Overall low RoB (v2)
Intervention characteristics												
Format; *n* (%)												
Individual	159 (34.5%)	51 (79.7%)	25 (41.0%)	26 (57.8%)	33 (89.2%)	82 (80.4%)	16 (50.0%)	10 (37%)	11 (37.9%)	20 (76.9%)	26 (38.2%)	45 (57.7%)
Group	144 (31.3%)		19 (31.1%)	9 (20.0%)	2 (5.4%)	9 (8.8%)	4 (12.5%)	4 (14.8%)	9 (31.0%)	6 (23.1%)	34 (50.0%)	21 (26.9%)
Guided self-help	99 (21.5%)	11 (17.2%)	14 (23.0%)	10 (22.2%)	1 (2.7%)	8 (7.8%)	5 (15.6%)		7 (24.1%)			[c]
Other/mixed	58 (12.6%)	2 (3.1%)	3 (4.9%)		1 (2.7%)	3 (2.9%)	7 (21.9%)	13 (48.2%)	2 (6.9%)		8 (11.8%)	12 (15.4%)
Number of sessions (*M*, *SD*)	8.9 (5.3)	9.3 (3.6)	11.0 (5.0)	11.6 (8.0)	3.8 (3.6)	8.2 (4.8)	12.4 (5.9)	48.5 (34.8)	7.6 (4.9)	7.6 (4.8)	28.0 (29.6)	13.0 (18.1)

Note. In two disorders (OCD and BPD), we defined low risk of bias less strictly and included studies with some concerns in the low category, because, in each of these data sets, only one study was available that was rated overall as low risk of bias. SAD = social anxiety disorder; GAD = generalized anxiety disorder; PTSD = posttraumatic stress disorder; OCD = obsessive–compulsive disorder; BPD = borderline personality disorder; v = Version.
[a] These analyses are based on a search conducted before January 1, 2023. Updates are in progress and will be released on Metapsy in 2024. [b] Study inclusion flowcharts for each indication are provided in the Supplemental Material S11. [c] Not listed separately.

and wait-lists because the latter has frequently been shown to overestimate the effects of psychological treatments (Cristea, 2019; Furukawa et al., 2014; Michopoulos et al., 2021). We only pooled the effects of treatments with at least five available trials. A random-effects model was assumed for all analyses, and between-study heterogeneity variances were estimated using the restricted maximum likelihood estimator.

Effects in LMICs and Non-Western Countries

To analyze the global effectiveness of psychological treatment, we also examined existing evidence for countries with different income levels and cultural backgrounds. Cultural context was considered alongside income levels to acknowledge that economic markers are not the sole criteria for classifying countries (Khan et al., 2022). We also deemed this to be an important indicator because many psychotherapies were initially developed in "Western" countries. As mentioned in the introduction, some theories state that contextual factors play an important role in psychological treatment (Wampold, 2017), which could cause differential effects depending on the cultural setting in which they are implemented. Overall, the goal of this analysis was to assess if there are regional factors based on which psychotherapy displays substantially smaller or larger effects—a relevant concern if psychological interventions are to be used as part of a "global" strategy to improve mental health care.

Our analytic approach is similar to previous reviews conducted specifically for depression (Cuijpers et al., 2018; Tong et al., 2023), but we have extended this to all 12 mental health problems covered in this meta-analysis. Using each trial's country of origin, we recorded the gross national income based on the purchasing power parity per capita in international dollars. Reference values were obtained from databases maintained by the World Bank, whose classification system was also used to categorize countries' income level as "low," "lower-middle," "upper-middle," and "high" (World Bank, 2024a). Historical data were used to ensure that the classification reflects the income level of a country at the time the trial was published.

Furthermore, we classified countries' cultural background as either "Western" or "non-Western." In our definition, Western regions included all countries of the European Union–27, the United States, Canada, the United Kingdom, Australia, New Zealand, Norway, Switzerland, and Iceland. All other countries were classified as "non-Western." In the absence of an established definition, our categorization was based on a consensus reached within the author team, which has members in both "Western" and "non-Western" regions thus classified.

Differences between income and cultural regions were examined by adding fixed predictors to the main meta-analysis models, resulting in a three-level correlated and hierarchical effects metaregression. In each regression model, the following variables were added as potential confounders, if feasible: intervention type and format, type of control group, publication year, mean age, percentage of women, risk of bias, number of treatment sessions, type of recruitment, type of diagnosis (clinician, cutoff), and population with comorbidities (yes, no). Before fitting the models, extreme effect sizes identified using the "leave-one-out" influence analysis were removed. Marginal mean effect sizes (Hedges's g) and their 95% confidence interval were then estimated from the fitted models for different income levels and cultural backgrounds, and across all 12 mental health problems. Model coefficients were used to test for effect differences between income categories and cultural background. Income category was entered as a dummy-coded predictor, with "high-income" serving as the reference category. This means that effects in upper middle, lower middle, and low-income countries are compared separately to effects in high-income countries. Effects in non-Western regions were directly compared to trials in Western regions, with the latter serving as the reference category.

Lastly, we also fitted Poisson models to examine changes in the number of published trials over time. These models included an interaction term between either income level or cultural background and time while controlling for the main effect of time on the number of trials published per year. Using these models, we tested if the growth in publication volume differed between income levels and cultural regions.

Transparency and Openness

The analysis has been registered with the Open Science Framework (Harrer, 2023) and it is indexed in the preregistration directory of the Metapsy initiative (https://metapsy.org/registrations#recHCFWeZtR4c5eHd). Analyses in LMICs and non-Western countries were added following feedback during peer-review and therefore do not appear in the original registration. All code and data are openly available on a Github repository (Harrer, 2024; https://github.com/MathiasHarrer/supersizing-meta-analysis). The repository provides a Docker container with a *renv* lockfile (Ushey & Wickham, 2023). This feature allows for the reproduction of the exact programming environment in which the analyses have been conducted and ensures that they remain reproducible even as new R and package versions are released. Using the Github "codespace" functionality, users can also open a code editor within the browser that allows them to directly rerun all the analyses we conducted. Instructions on how to set up the codespace are provided in the "readme" file.

Results

Aggregated study characteristics are summarized in Table 1. In total, 1,029 studies were included. Collectively, these randomized trials enrolled 85,952 patients: 44,997 in the intervention group and 40,955 in the control group. The number of available studies differed substantially between indications: There were 460 RCTs on depression treatments, whereas only 26 studies investigated the effects of problem gambling interventions. Patient numbers showed a similar pattern, ranging from 1,249 for specific phobia to 43,771 patients included in depression trials. The proportion of studies recruiting from clinical populations ranged from 5.4% for specific phobias to 85.3% for psychosis. Mean ages were roughly comparable, with slightly younger samples for BPD (31.8 years) and phobias (32.4 years). Females made up the majority of patients for all conditions except for gambling and psychosis. Even though the criteria varied between analyses, low-risk-of-bias studies were in the minority across all indications. The mean number of sessions was mostly comparable across all mental health problems except for psychosis ($M = 28.0$) and for BPD, where treatments included almost 50 sessions on average. Wait-lists were the most common comparator for psychological treatments of anxiety disorders, PTSD, OCD, prolonged grief, and gambling. For depression, BPD, and psychosis, care-as-usual comparators were used more frequently.

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A forest plot of the pooled treatment effects can be seen in Figure 3. Psychological treatments had a positive and significant effect for all of the studied conditions, but the size of this effect varied considerably. Small to moderate benefits were found for treatments targeting psychosis, suicidal ideation, BPD, and prolonged grief (g = 0.32–0.49), with the NNT ranging from 15 to 6. Larger effects were found for depression, gambling, panic disorder, GAD, and SAD interventions (g = 0.73–0.95), where the NNT ranged from 5 to 4 patients. The largest effects were yielded by treatments for OCD, PTSD, and specific phobias (g = 1.18–1.25; NNT: 4–3). Estimates of the between-study heterogeneity variance $\hat{\tau}^2_{\text{between}}$ indicated that studies' true effects varied to a nonnegligible degree across all mental health problems. For all indications except OCD, the 95% prediction intervals included zero, which means that we cannot rule out that there are contexts in which future studies will yield negative effects.

Results of the sensitivity analyses are presented in Supplemental Material S13. These analyses largely confirmed the robustness of the calculated effects. For suicidal ideation, BPD, problem gambling, and prolonged grief, correction of small-study effects via a limited meta-analysis led to shrunken effect estimates that were not significant anymore (g = −0.08 to 0.16). For prolonged grief, the selection model additionally pointed to a problem with selective publication (χ^2 = 7.647, p = .006), and the effect estimate reduced to g = 0.14 (p = .648). Similar results were observed for suicidal ideation (g = 0.18, p = .030; χ^2 = 6.579, p = .010). When only low-risk-of-bias studies were considered, the effect of gambling interventions shrank down to g = 0.07, which was no longer significant (p = .305).

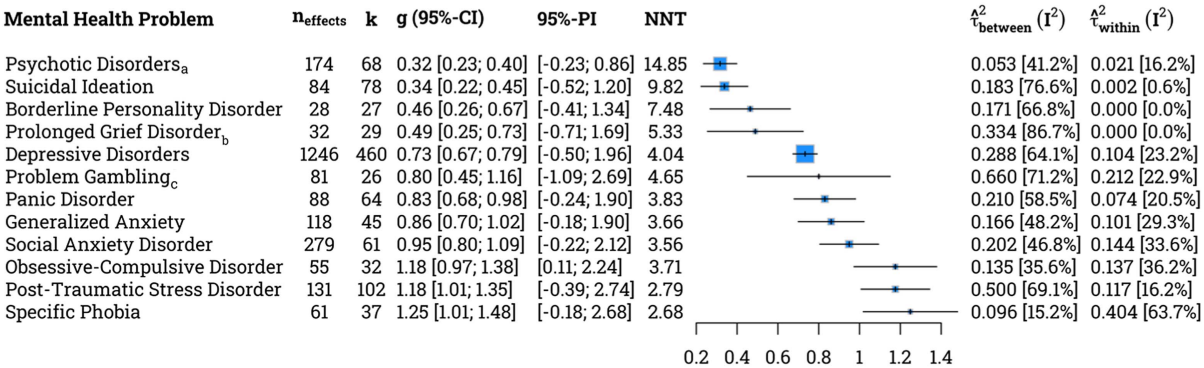
Results of the subgroup-specific analyses are presented in Table 2. After conditioning on the treatment type and comparator, we observed two general patterns. First, for almost all indications, cognitive behavioral therapies are the most frequently studied type of treatment. For depression, the number of trials examining CBT (257 trials) even surpasses all other treatment types by orders of magnitude. However, we did not find any strong indications that the efficacy of CBT (g = 0.24–1.19) is higher than that of other treatments. A second observation is that the effects of psychological treatments compared to care-as-usual tend to be lower than those compared to wait-lists. Even when looking at these smaller subsets, we found that most effects remained heterogeneous, with up to 90% of the effect variation not being attributable to sampling error.

Figure 4 displays the number of trials by country. The map on the top shows that most evidence on psychotherapy effects comes from Western countries, with three anglophone countries (United States: k = 332; United Kingdom: k = 111; Australia: k = 67) leading the list. The United States alone make up 32% of the total publication volume included in our analysis. A slightly different picture emerged when publication numbers were standardized by countries' population, where two European countries, Sweden and the Netherlands, are particularly productive (4.2 and 3.9 trials per 1 million inhabitants, respectively; see bottom map). The lowest per capita rate can be found in India, where there is only roughly one trial per 250 million inhabitants. Exact publication numbers for each country are provided in Supplemental Material S14.

Although strongly imbalanced, these maps show that included studies were conducted in all major regions of the world, including East Asia, the Middle East, Latin America, and sub-Saharan Africa. Overall, 86.1% (k = 884) of all studies were conducted in Western regions and 13.9% (k = 143) in non-Western countries. Similarly, 83.4% (k = 856) of all trials came from high-income countries, 16.2% (k = 167) from middle-income countries, whereas only 0.4% (k = 4) were conducted in low-income regions of the world. In Figure 5, we show how the share of LMIC and non-Western studies has developed over the past 50 years. The left side of the figure displays the predicted publication numbers per year based on the fitted Poisson models. These graphs show that scientific output has risen tremendously across almost all income levels and cultural regions, but at different speeds. In particular, we found that publication rates are growing significantly faster in lower middle-income ($\hat{\beta}$ = 1.064, SE = 0.400; p = .008) and upper middle-income countries ($\hat{\beta}$ = 0.730, SE = 0.284; p = .010), compared to high-income countries. The publication volume is also growing faster in non-Western compared to Western countries ($\hat{\beta}$ = 1.005, SE = 0.239; p < .001). The right graph in Figure 5 shows that trials before the year 2000 were almost

Figure 3

Effects of Psychological Treatment on 12 Mental Health Problems



Note. Subscript lowercase letters a, b, and c indicate these analyses are based on searches conducted before 2023. Updates are in progress and will be released on Metapsy in 2024. Psychological treatments are compared to wait-list, care-as-usual, or other controls (e.g., attention placebo). All values of Hedges's g were coded so that values with a positive sign indicate favorable effects of psychological treatment compared to control. CI = confidence interval; NNT = numbers needed to treat; PI = prediction interval. See the online article for the color version of this figure.

Table 2
Meta-Analytic Effects of Specific Psychological Treatments

Treatment	Comparator	n_{comp}	g [95% CI]	I^2 [95% CI]	NNT
Borderline personality disorder					
Dialectic behavioral therapy	Care-as-usual	10	0.38 [0.11, 0.64]	34.7% [0.00%, 68.9%]	9.45
Depressive disorders					
Third-wave CBT	Wait-list	20	0.95 [0.54, 1.36]	77.1% [64.9%, 85.0%]	2.91
	Care-as-usual	12	0.82 [0.47, 1.17]	75.2% [56.3%, 85.9%]	3.43
Behavioral activation	Wait-list	12	0.97 [0.74, 1.21]	17.9% [0.00%, 57.2%]	2.85
	Care-as-usual	24	0.66 [0.45, 0.86]	79.7% [70.5%, 86.1%]	4.39
Cognitive behavioral therapy	Wait-list	129	0.96 [0.83, 1.09]	80.5% [77.2%, 83.4%]	2.88
	Care-as-usual	128	0.68 [0.55, 0.82]	87.6% [85.7%, 89.2%]	4.24
Psychodynamic therapy	Care-as-usual	8	0.33 [0.05, 0.61]	70.6% [39.2%, 85.8%]	9.57
Interpersonal therapy	Care-as-usual	24	0.44 [0.26, 0.62]	76.0% [64.4%, 83.8%]	6.95
Life review therapy	Wait-list	5	0.56 [0.25, 0.87]	26.8% [0.00%, 71.0%]	5.29
	Care-as-usual	7	1.70 [1.11, 2.30]	71.3% [37.6%, 86.8%]	1.65
Problem-solving therapy	Wait-list	15	0.81 [0.41, 1.20]	81.1% [69.9%, 88.2%]	3.48
	Care-as-usual	13	0.57 [0.24, 0.90]	83.8% [73.7%, 90.0%]	5.18
Supportive counseling	Care-as-usual	13	0.41 [0.27, 0.54]	7.9% [0.00%, 45.4%]	7.52
Problem gambling[a]					
Cognitive behavioral therapy	Wait-list	24	0.74 [0.38, 1.10]	84.8% [78.5%, 89.2%]	5.15
	Care-as-usual	7	0.24 [−0.08, 0.55]	68.6% [30.7%, 85.8%]	20.49
Generalized anxiety disorder					
Third-wave CBT	Wait-list	5	1.38 [0.55, 2.21]	83.5% [62.6%, 92.7%]	2.09
Applied relaxation	Wait-list	5	0.77 [0.31, 1.23]	24.2% [0.00%, 69.2%]	4.20
Cognitive behavioral therapy	Wait-list	27	0.87 [0.67, 1.06]	68.4% [53.1%, 78.8%]	3.61
	Care-as-usual	6	0.96 [0.09, 1.84]	86.8% [73.6%, 93.4%]	3.20
Prolonged grief disorder[a]					
Cognitive behavioral therapy	Wait-list	6	0.85 [−0.08, 1.78]	87.1% [74.1%, 93.5%]	3.31
Writing therapy	Wait-list	5	0.59 [−0.10, 1.27]	80.9% [55.3%, 91.8%]	4.50
Obsessive–compulsive disorder					
Cognitive behavioral therapy	Wait-list	9	1.11 [0.95, 1.27]	0.00% [0.00%, 64.8%]	4.06
Exposure and response prevention	Wait-list	5	1.52 [0.38, 2.66]	81.5% [57.1%, 92.0%]	2.50
Panic disorder					
Behavior therapy	Wait-list	10	1.41 [0.96, 1.85]	57.1% [13.2%, 78.8%]	2.04
Cognitive behavioral therapy	Wait-list	37	1.03 [0.81, 1.24]	70.7% [59.1%, 79.0%]	2.94
	Care-as-usual	11	0.70 [0.23, 1.17]	80.4% [65.9%, 88.8%]	4.72
Physiological therapy	Wait-list	6	0.89 [0.20, 1.58]	64.6% [14.8%, 85.3%]	3.51
Specific phobia					
Cognitive behavioral therapy	Wait-list	6	1.14 [0.03, 2.25]	90.0% [80.8%, 94.7%]	3.03
Exposure	Wait-list	35	1.28 [1.01, 1.54]	74.3% [64.2%, 81.5%]	2.59
	Care-as-usual	5	1.47 [0.12, 2.81]	80.8% [55.2%, 91.8%]	2.17
Suicidal ideation					
Cognitive behavioral therapy	Wait-list	5	0.79 [−0.67, 2.25]	85.6% [68.3%, 93.5%]	3.58
	Care-as-usual	23	0.38 [0.12, 0.65]	70.5% [55.0%, 80.7%]	8.18
Family intervention	Care-as-usual	10	0.27 [0.01, 0.53]	44.4% [0.00%, 73.3%]	11.93
Psychotic disorders[a]					
Cognitive remediation	Care-as-usual	23	0.30 [0.14, 0.47]	53.6% [25.5%, 71.1%]	15.83
Cognitive behavioral therapy	Care-as-usual	23	0.29 [0.15, 0.42]	49.0% [17.3%, 68.5%]	16.47
Posttraumatic stress disorder					
EMDR	Wait-list	11	1.90 [1.05, 2.74]	88.9% [82.2%, 93.1%]	1.58
Non-trauma-focused	Wait-list	16	1.14 [0.68, 1.59]	79.8% [67.9%, 87.2%]	2.91
	Care-as-usual	8	0.44 [0.17, 0.72]	17.3% [0.00%, 60.2%]	10.00
Trauma-focused CBT	Wait-list	48	1.19 [0.95, 1.42]	76.9% [69.6%, 82.4%]	2.75
	Care-as-usual	8	0.76 [0.44, 1.08]	1.4% [0.00%, 68.0%]	4.98
Other trauma-focused	Wait-list	6	1.80 [0.59, 3.01]	76.1% [46.3%, 89.3%]	1.67
Social anxiety disorder					
Third-wave CBT	Wait-list	6	1.08 [0.44, 1.73]	75.2% [43.9%, 89.0%]	3.01
Cognitive behavioral therapy	Wait-list	47	0.96 [0.79, 1.13]	71.2% [61.5%, 78.5%]	3.51
Exposure	Wait-list	11	0.78 [0.47, 1.08]	61.4% [25.5%, 80.0%]	4.60

Note. Only treatments with at least five comparisons are reported. All values of Hedges's g were coded so that values with a positive sign indicate favorable effects of psychological treatment compared to control. CI = confidence interval; NNT = numbers needed to treat; CBT = cognitive behavioral therapy; comp = comparison; EMDR = eye-movement desensitization and reprocessing.
[a] These analyses are based on a search conducted before January 1, 2023. Updates are in progress and will be released on Metapsy in 2024.

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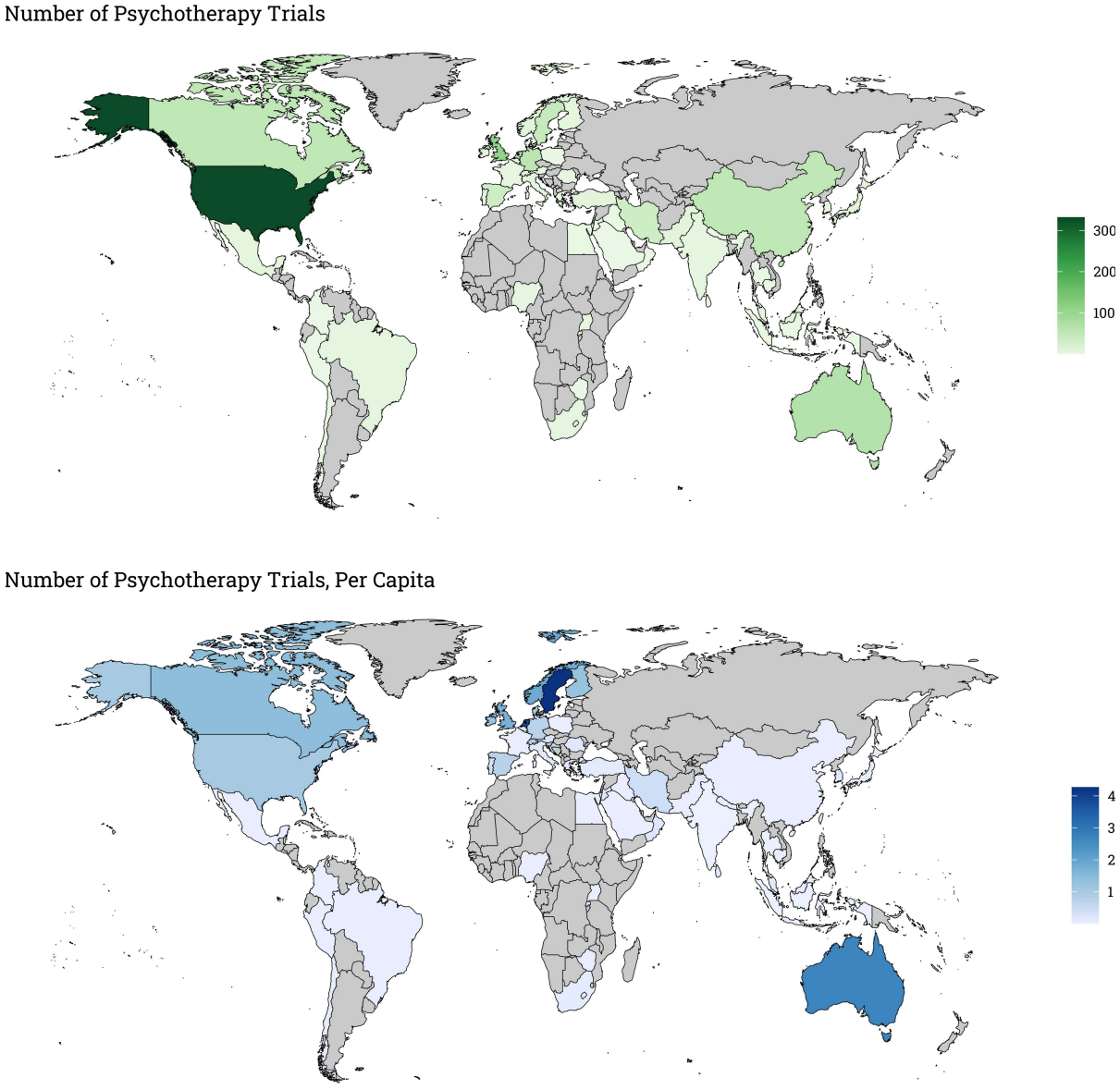
Figure 4

Number of Psychotherapy Trials by Country



Note. Trial numbers are based on studies selected for this meta-analysis from the Metapsy databases for depression, panic disorder, social anxiety disorder, generalized anxiety disorder, specific phobia, posttraumatic stress disorder, obsessive–compulsive disorder, borderline personality disorder, prolonged grief disorder, problem gambling, psychosis, and suicidal ideation ($k = 1{,}029$). The lower map shows the number of psychotherapy trials per 1 million inhabitants. These numbers were derived using world population estimates for 2017 (World Bank; "sp.pop.totl" database). Exact numbers for each country are provided in Supplemental Material S14. See the online article for the color version of this figure.

exclusively conducted in high-income Western countries. Since then, their share among newly published trials has been falling steadily.

Table 3 shows further study characteristics conditional on income level and cultural background. In terms of treatment format, group-based interventions were more common in middle-income countries (46.7%; $k = 78$) compared to high-income countries (20.9%; $k = 178$), whereas guided self-help was less frequently studied (middle-income: 9.0%, $k = 15$; high-income: 16.8%, $k = 143$). This pattern extended to non-Western (group-based: 38.5%, $k = 55$; guided self-help: 7.7%, $k = 11$) versus Western (group-based: 23.2%, $k = 204$; guided self-help: 16.8%, $k = 148$) countries. In both middle-income (55.1%, $k = 92$) and non-Western countries (58.0%, $k = 83$), care-as-usual conditions were more common (high-income Western countries: 39.0%–39.1%). LMICs had studies with higher sample sizes (mean $N = 102$–155; vs. 73 in high-income countries) and

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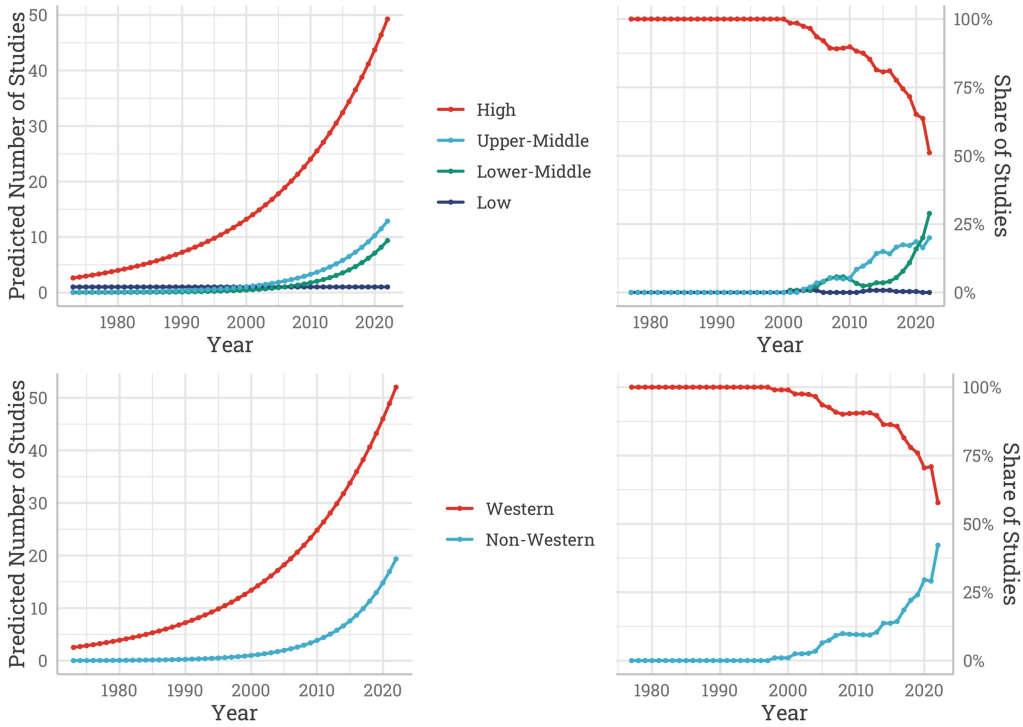
Figure 5

Number of Psychotherapy Trials per Country Income Level (Top) and Cultural Region (Bottom)



Note. Trial numbers are based on studies selected for this meta-analysis from the Metapsy databases for depression, panic disorder, social anxiety disorder, generalized anxiety disorder, specific phobia, posttraumatic stress disorder, obsessive–compulsive disorder, borderline personality disorder, prolonged grief disorder, problem gambling, psychosis, and suicidal ideation ($k = 1{,}029$). Graphs to the left show the predicted number of trials per year based on a Poisson model. These models include the main effect of time, as well as an interaction term between time and income level/cultural region. Percentages of the studies to the right were computed using a 5-year rolling average. See the online article for the color version of this figure.

slightly fewer studies with a low risk of bias (22.8%, $k = 39$; vs. 24.3% in high-income regions). Such differences did not emerge for Western versus non-Western trials.

Effect sizes of psychological treatment across all income levels and cultural regions are displayed in Table 4. Point estimates of the effect size tended to be larger in LMICs compared to high-income countries. This difference was only significant for depression, PTSD, and suicidal ideation ($\Delta_g = 0.24$–1.40). Findings for cultural regions were similar, with significantly larger effects in non-Western countries among treatments for PTSD, prolonged grief disorder, psychosis, and suicidal ideation ($\Delta_g = 0.50$–1.92). Significant effects in LMICs could be ascertained for depression ($g = 0.93$–1.04), SAD ($g = 1.01$), GAD ($g = 0.86$), PTSD ($g = 1.35$–2.41), OCD ($g = 1.44$–1.90), BPD ($g = 1.94$), psychosis ($g = 0.72$), and suicidal ideation ($g = 0.38$–0.90), although not consistently among all income levels. In low-income countries, in particular, positive evidence was only available for depression treatments ($g = 1.04$). Among non-Western countries, significant effects were found for depression ($g = 1.01$), SAD ($g = 0.79$), GAD ($g = 0.86$), PTSD ($g = 1.56$), OCD ($g = 1.76$), BPD ($g = 1.94$), complicated grief ($g = 2.20$), psychosis ($g = 0.74$), and suicidal ideation ($g = 0.76$).

Discussion

This article introduced the MARD concept and described its implementation as part of the Metapsy initiative. We used this novel database infrastructure to conduct a large-scale meta-analysis, encompassing 1,029 psychotherapy trials with 85,952 patients across 12 mental health problems. We found that psychotherapy is effective for all studied indications: depression, GAD, SAD, panic disorder, specific phobias, OCD, PTSD, BPD, psychosis, prolonged grief, problem gambling, and suicidal ideation. CBT was the most frequently studied treatment format, but our results do not indicate that its effects are larger than those of other therapies. Effect estimates were generally smaller if therapies were compared to care as usual instead of wait-lists. Finally, we also examined available evidence from a global perspective and estimated the benefits of psychological treatment across all income levels and cultural regions. We find that trials from high-income Western countries still dominate the existing evidence base but that the number of RCTs in non-Western countries and LMICs is now strongly increasing. A synthesis of these trials revealed no signs that psychological treatments are less effective outside the high-income Western context in which most were initially developed.

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Table 3
Study Characteristics per Country Income Level and Cultural Region

Study characteristic	Country income level				Cultural region	
	High	Upper middle	Lower middle	Low	Western	Non-Western
Number of trials	852 (83.3%)	104 (10.2%)	63 (6.2%)	4 (0.4%)	880 (86.0%)	143 (14.0%)
Publication year						
Before 1980	7 (100%)	0 (0%)	0 (0%)	0 (0%)	7 (100%)	0 (0%)
1980–1984	16 (100%)	0 (0%)	0 (0%)	0 (0%)	16 (100%)	0 (0%)
1985–1989	21 (100%)	0 (0%)	0 (0%)	0 (0%)	21 (100%)	0 (0%)
1990–1994	27 (100%)	0 (0%)	0 (0%)	0 (0%)	27 (100%)	0 (0%)
1995–1999	50 (100%)	0 (0%)	0 (0%)	0 (0%)	50 (100%)	0 (0%)
2000–2004	86 (97.8%)	0 (0%)	1 (1.1%)	1 (1.1%)	85 (96.6%)	3 (3.4%)
2005–2009	131 (88.6%)	8 (5.4%)	9 (6%)	0 (0%)	134 (90.5%)	14 (9.5%)
2010–2014	203 (86.8%)	24 (10.3%)	6 (2.6%)	1 (0.4%)	211 (90.2%)	23 (9.8%)
2015–2019	210 (78.1%)	44 (16.4%)	14 (5.2%)	1 (0.4%)	218 (81.6%)	49 (18.4%)
Since 2020	101 (62%)	28 (17.2%)	33 (20.2%)	1 (0.6%)	109 (66.9%)	54 (33.1%)
Disorder						
Depression	362 (78.7%)	54 (11.7%)	41 (8.9%)	3 (0.7%)	382 (83%)	78 (17%)
Panic disorder	59 (98.3%)	1 (1.7%)	0 (0%)	0 (0%)	59 (98.3%)	1 (1.7%)
Social anxiety disorder	54 (90.0%)	4 (6.7%)	2 (3.3%)	0 (0%)	56 (93.3%)	4 (6.7%)
Generalized anxiety disorder	41 (87.2%)	3 (6.4%)	3 (6.4%)	0 (0%)	42 (89.4%)	5 (10.6%)
Specific phobia	35 (97.2%)	1 (2.8%)	0 (0%)	0 (0%)	35 (97.2%)	1 (2.8%)
Posttraumatic stress disorder	86 (84.3%)	11 (10.8%)	4 (3.9%)	1 (1%)	84 (82.4%)	18 (17.6%)
Obsessive–compulsive disorder	25 (78.13%)	5 (15.6%)	2 (6.3%)	0 (0%)	25 (78.1%)	7 (21.9%)
Borderline personality disorder	26 (96.3%)	1 (3.7%)	0 (0%)	0 (0%)	26 (96.3%)	1 (3.7%)
Complicated grief	29 (100%)	0 (0%)	0 (0%)	0 (0%)	27 (93.1%)	2 (6.9%)
Problem gambling	24 (96%)	1 (4%)	0 (0%)	0 (0%)	24 (96%)	1 (4%)
Psychosis	50 (73.5%)	15 (22.1%)	3 (4.4%)	0 (0%)	58 (85.3%)	10 (14.7%)
Suicidality	61 (79.2%)	8 (10.4%)	8 (10.4%)	0 (0%)	62 (80.5%)	15 (19.5%)
Intervention format						
Individual	442 (88.9%)	32 (6.4%)	22 (4.4%)	1 (0.2%)	440 (88.5%)	57 (11.5%)
Group	178 (68.7%)	51 (19.7%)	27 (10.4%)	3 (1.2%)	204 (78.8%)	55 (21.2%)
Guided self-help	143 (90.5%)	8 (5.1%)	7 (4.4%)	0 (0%)	148 (93.1%)	11 (6.9%)
Other/mixed	88 (81.5%)	13 (12%)	7 (6.5%)	0 (0%)	88 (81.5%)	20 (18.5%)
Type of control						
Wait-list	383 (87.6%)	33 (7.6%)	20 (4.6%)	1 (0.2%)	397 (90.8%)	40 (9.2%)
Care-as-usual	333 (78.2%)	63 (14.8%)	29 (6.8%)	1 (0.2%)	343 (80.5%)	83 (19.5%)
Other characteristics						
Sample size (*M*, *SD*)	73 (78.7)	102 (130)	105 (137)	155 (113)	77.1 (88.3)	85.0 (107)
Low risk of bias	207 (84.1%)	19 (7.7%)	18 (7.3%)	2 (0.8%)	209 (85.0%)	37 (15.0%)
Clinical recruitment	281 (83.9%)	38 (11.3%)	16 (4.8%)	0 (0%)	289 (86.3%)	46 (13.7%)

Note. Unless otherwise specified, cells provide the number of studies, with percentages within the category in brackets.

In the following, we provide a more detailed discussion of our findings, their relationship to previous evidence, and potential future directions for psychotherapy research. Additionally, we address the limitations of our current synthesis and the MARD concept in general.

Effectiveness of Psychological Treatment

In the middle of the 20th century, Eysenck (1952) infamously concluded that psychotherapy is inefficacious and would often even hinder patients from improving. It should be noted that, at that time, this criticism was largely directed at psychodynamic therapies, not the cognitive behavioral interventions that started to emerge at the time (Cuijpers, Karyotaki, Reijnders, et al., 2019). Even so, the results of our meta-analysis demonstrate that Eysenck's verdict was wrong: We found that psychological treatments are effective for all of the 12 mental health problems we studied (see Figure 3). This effect remained robust across almost all sensitivity analyses and after applying various publication bias corrections (see Supplemental Material S13).

However, the effect size varied drastically by indication. In line with previous meta-analytic reviews (Bighelli et al., 2018; Cristea et al., 2017; Mc Glanaghy et al., 2021; Wood et al., 2020), only a small to moderate benefit was found for treatments of psychosis ($g = 0.32$) and borderline personality disorder ($g = 0.46$), both conditions that are often regarded as "difficult to treat" (Arntz, 1994; Kirkpatrick et al., 2006; Sarkar et al., 2015). In treatments for BPD, there was a striking divergence between the low effects on the one side and the mean number of sessions on the other side, which was much higher than that of all other conditions (48.5 vs. 3.8–11.8; see Table 1). Furthermore, we could not ascertain a significant treatment effect after high-risk-of-bias studies were excluded. Among specific treatment formats, dialectic behavioral therapy had the largest evidence base in our analysis, but its effects were also small ($g = 0.38$). The pooled effect for prolonged grief fell into a similar region ($g = 0.49$) but was highly heterogeneous ($\hat{\tau}^2_{\text{between}} = 0.334$; $I^2 = 86.7\%$). Further inspection revealed that cognitive behavioral treatment ($g = 0.85$) had a higher effect than letter writing ($g = 0.59$). This is a plausible finding given that the latter is a less intensive kind of intervention when provided as stand-alone treatment.

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Table 4
Effects of Psychotherapy Across Country Income Levels and Cultural Regions

Indication	*k*	*g*	95% CI	NNT	Δ_g	*t*	*p*	$\widehat{\tau}^2_{within}$	$\widehat{\tau}^2_{between}$
Borderline personality disorder									
Income level									
High	26	0.45	[0.19, 0.71]	7.74	ref.			0.000	0.255
Upper middle	1	1.94	[0.03, 3.85]	1.50	1.49	1.636	.124		
Cultural region									
Western	26	0.45	[0.19, 0.71]	7.74	ref.			0.000	0.255
Non-Western	1	1.94	[0.03, 3.85]	1.50	1.49	1.636	.124		
Depression									
Income level									
High	359	0.69	[0.64, 0.74]	4.36	ref.			0.090	0.091
Upper middle	52	0.93	[0.78, 1.07]	3.09	0.24	3.175	.002		
Lower middle	34	0.98	[0.81, 1.15]	2.90	0.29	3.318	<.001		
Low	2	1.04	[0.43, 1.65]	2.70	0.36	1.146	.252		
Cultural region									
Western	379	0.69	[0.64, 0.74]	4.33	ref.			0.090	0.091
Non-Western	68	1.01	[0.88, 1.14]	2.79	0.32	1.146	.252		
Problem gambling[a]									
Income level									
High	24	0.68	[0.49, 0.87]	5.77	ref.			0.201	0.066
Upper middle	1	−0.12	[−1.35, 1.10]	49.73	−0.80	−1.275	.207		
Cultural region									
Western	24	0.66	[0.46, 0.86]	6.00	ref.			0.197	0.100
Non-Western	1	0.60	[−0.61, 1.80]	6.83	−0.06	−0.100	.920		
Generalized anxiety disorder									
Income level									
High	40	0.87	[0.67, 1.07]	3.61	ref.			0.068	0.149
Upper middle	3	0.86	[0.11, 1.61]	3.68	−0.01	−0.030	.976		
Lower middle	3	1.14	[−0.03, 2.32]	2.59	0.27	0.434	.666		
Cultural region									
Western	41	0.89	[0.70, 1.08]	3.52	ref.			0.068	0.146
Non-Western	5	0.86	[0.12, 1.60]	3.68	−0.03	−0.080	.936		
Prolonged grief disorder[a]									
Income level									
High	29	0.49	[0.25, 0.73]	5.33				0.000	0.334
Cultural region									
Western	26	0.27	[0.03, 0.52]	9.27	ref.			0.000	0.255
Non-Western	2	2.20	[0.79, 3.60]	2.06	1.92	2.685	.015		
Obsessive–compulsive disorder									
Income level									
High	25	1.13	[0.84, 1.43]	3.93	ref.			0.162	0.131
Upper middle	5	1.90	[0.88, 2.91]	1.82	0.76	1.336	.190		
Lower middle	2	1.44	[0.22, 2.66]	2.70	0.31	0.468	.643		
Cultural region									
Western	25	1.11	[0.82, 1.41]	4.04	ref.			0.159	0.111
Non-Western	7	1.76	[0.90, 2.62]	2.01	0.65	1.285	.207		
Panic disorder									
Income level									
High	62	0.90	[0.74, 1.06]	3.49	ref.			0.178	0.086
Upper middle	1	1.08	[−0.24, 2.40]	2.79	0.18	0.270	.788		
Cultural region									
Western	62	0.90	[0.74, 1.06]	3.46	ref.			0.175	0.087
Non-Western	1	0.68	[−1.13, 2.50]	4.88	−0.22	−0.240	.810		
Specific phobia									
Income level									
High	36	1.26	[1.03, 1.50]	2.64	ref.			0.308	0.107
Upper middle	1	1.75	[−0.01, 3.51]	1.76	0.49	0.555	.582		
Cultural region									
Western	36	1.26	[1.03, 1.50]	2.64	ref.			0.308	0.107
Non-Western	1	1.75	[−0.01, 3.51]	1.76	0.49	0.555	.582		
Suicidal ideation									
Income level									
High	62	0.22	[0.12, 0.31]	16.11	ref.			0.008	0.044
Upper middle	6	0.38	[0.08, 0.68]	8.60	0.16	1.002	.321		
Lower middle	8	0.90	[0.61, 1.20]	3.18	0.68	4.324	<.001		

(*table continues*)

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Table 4 (*continued*)

Indication	*k*	*g*	95% CI	NNT	Δ_g	*t*	*p*	$\widehat{\tau}^2_{within}$	$\widehat{\tau}^2_{between}$
Cultural region									
Western	63	0.21	[0.12, 0.30]	16.85	ref.			0.008	0.041
Non-Western	13	0.76	[0.52, 0.99]	3.89	0.55	4.204	<.001		
Psychotic disorders[a]									
Income level									
High	49	0.35	[0.23, 0.47]	13.22	ref.			0.019	0.042
Upper middle	15	0.20	[−0.04, 0.45]	24.99	−0.15	−0.949	.344		
Lower middle	3	0.72	[0.25, 1.19]	5.34	0.37	1.544	.125		
Cultural region									
Western	57	0.24	[0.15, 0.32]	20.95	ref.			0.019	0.014
Non-Western	10	0.74	[0.53, 0.95]	5.19	0.50	4.125	<.001		
Posttraumatic stress disorder									
Income level									
High	86	1.01	[0.87, 1.15]	3.41	ref.			0.068	0.184
Upper middle	9	1.35	[0.88, 1.82]	2.33	0.34	1.378	.171		
Lower middle	3	2.41	[1.66, 3.15]	1.30	1.40	3.612	<.001		
Low	1	0.42	[−0.80, 1.64]	10.60	−0.59	−0.951	.344		
Cultural region									
Western	84	1.00	[0.86, 1.15]	3.45	ref.			0.069	0.218
Non-Western	15	1.56	[1.19, 1.93]	1.96	0.56	2.681	.009		
Social anxiety disorder									
Income level									
High	55	0.94	[0.79, 1.10]	3.59	ref.			0.134	0.173
Upper middle	4	1.01	[0.33, 1.70]	3.27	0.07	0.199	.842		
Lower middle	2	0.74	[−0.24, 1.71]	4.94	−0.21	−0.415	.679		
Cultural region									
Western	57	0.95	[0.80, 1.10]	3.57	ref.			0.134	0.165
Non-Western	4	0.79	[0.10, 1.49]	4.49	−0.15	−0.428	.669		

Note. Estimated marginal mean effect sizes and regression coefficients are based on a three-level correlated and hierarchical effects model. Models were controlled for intervention type, intervention format, control group type, publication year, mean age, percentage of women, risk of bias, number of treatment sessions, type of recruitment, type of diagnosis (clinician, cutoff), and comorbidity population, if available. Outliers and influential cases determined using the "leave-one-out" method were removed before model fitting. All values of Hedges's *g* were coded so that values with a positive sign indicate favorable effects of psychological treatment compared to control. Ref. = reference category; CI = confidence interval; NNT = numbers needed to treat.

[a] These analyses are based on a search conducted before January 1, 2023. Updates are in progress and will be released on Metapsy in 2024.

Moderate to high effects were found for psychological treatments of depression ($g = 0.73$), problem gambling ($g = 0.80$), panic disorder ($g = 0.83$), GAD ($g = 0.86$), and SAD ($g = 0.95$). For depression, our meta-analysis documents that a substantial evidence base for psychological treatments has accumulated within the past decades, and it corroborates the results of previous reviews (Cuijpers, Miguel, Harrer, Plessen, Ciharova, Papola, et al., 2023; Cuijpers, Quero, Noma, et al., 2021; Munder et al., 2019). A total of 460 depression trials could be included, almost half of the total number of studies included in this meta-analysis. Our findings also show that CBT dominates the research landscape for depression, contributing to more than 250 trials (see Table 2). Others have made similar observations, and a recent study found that the research output for CBT is also growing faster than that of most other treatments (Cuijpers, Harrer, et al., 2023). This means that the dominance of CBT in depression research will probably increase in the future. Because the efficacy of CBT compared to control groups has been demonstrated in so many trials, one could argue that further RCTs are unlikely to add much and that other types of comparisons should be prioritized (Cuijpers, Miguel, Harrer, Plessen, Ciharova, Papola, et al., 2023). It may also be more relevant to instead examine how such treatments can be more successfully implemented in practice (Bauer & Kirchner, 2020). In this meta-analysis, we did not detect any clear indications that other therapies are more or less effective than CBT, even though their evidence base is smaller. Even NDST showed a respectable effect of $g = 0.41$ compared to care-as-usual conditions. This is in line with previous meta-analyses (Cuijpers et al., 2012; Cuijpers, Miguel, Harrer, Ciharova, et al., 2024). We may have even underestimated the true benefits of this treatment, which is often used as an "intent-to-fail" intervention in psychotherapy research (Cuijpers et al., 2012; Cuijpers, Miguel, Ciharova, Harrer, & Karyotaki, 2024). Generally, it should be noted that this meta-analysis did not focus on RCTs providing head-to-head comparisons between two active psychological treatments, which are required to create more robust evidence on the relative efficacy of different psychological treatments. Further studies that include such comparisons within the Metapsy databases as part of a network meta-analytic approach might be a promising area for future research.

Large effects were found for OCD ($g = 1.18$), PTSD ($g = 1.18$), and specific phobias ($g = 1.25$). All major treatment types for these disorders showed a very high effectiveness ($g = 0.76$–1.90), except for non-trauma-focused PTSD treatments ($g = 0.44$ compared to usual care). For PTSD, we also found large effects of eye-movement desensitization and reprocessing ($g = 1.90$, $k = 11$) compared to wait-lists, a treatment that has been controversial in the past due to its unclear scientific foundations (Lee & Cuijpers, 2013; Schubert & Lee, 2009). Large effects were also found for trauma-focused CBT ($g = 1.19$, $k = 48$), which is a first-line recommendation in the most prominent clinical practice guidelines for PTSD (Hamblen et al., 2019). Exposure-based therapies showed a strong evidence base

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for specific phobias, which is in line with previous meta-analytic reviews (Wolitzky-Taylor et al., 2008).

Psychological Treatment Research: A Global Endeavor

Our findings highlight a few more fundamental shifts in psychotherapy research over the past decades. One of these changes is the rapid globalization of the field, as evidenced by an increasing number of randomized trials conducted in LMICs and non-Western regions (see Figures 4 and 5). In our introduction, we argued that this development is not unique: it reflects the expansion of psychological science as a whole, leading to a stark increase in the volume of published evidence globally. In psychotherapy research, this development is juxtaposed with the near-complete dominance of Western countries before 2000. We find that, despite gradual changes, more than 80% of the existing evidence on psychotherapy effects still comes from trials in high-income, Western countries. There is an increasing sensitivity to the fact that much of psychological research is restricted to Western, educated, industrialized, rich, and democratic societies (Henrich et al., 2010), and our analyses show that psychotherapy research is not much of an exception. It is important to stress that our differentiation between "Western" and "non-Western" countries is arbitrary. Some of the countries we classified as non-Western in this analysis might be considered Western by others, and vice versa (cf. Khan et al., 2022). The main purpose of our investigation was to examine if psychological treatments are also effective outside of the countries in which many of these formats were originally developed and their particular cultural context (i.e., North America, Europe, and Australia).

Our findings indicate that psychotherapies are effective in non-Western regions and that they can be successfully implemented in LMICs as well (see Table 4). Our meta-analysis corroborates and extends existing evidence on treatments for depression and anxiety (Barbui et al., 2020; Cuijpers et al., 2018; Tong et al., 2023), PTSD (Morina et al., 2017), as well as digital interventions (Fu et al., 2020). In previous reviews (Tong et al., 2023; Venturo-Conerly et al., 2023), benefits in LMICs and non-Western countries were larger compared to high-income Western countries, even after controlling for factors typically associated with differential treatment effects (e.g., intervention format, type of comparator, or risk of bias; Cuijpers et al., 2018). Yet, this contrast did not emerge across all income levels and mental health problems. The cause for this pattern is unclear: it might represent genuine differences in the true effect of treatment or it might result from more subtle confounding that our models could not account for. Previous studies have argued that assessment practices could also play a role here (Tong et al., 2023). Furthermore, "care as usual" provided in control groups is likely to have a lower quality in LMICs compared to countries with well-developed health care systems, which could explain higher effects in these countries (Cuijpers, Quero, Papola, et al., 2021). In any case, we found no evidence that psychological treatment is less effective outside of high-income Western countries.

Our results show that group-based interventions are more common in LMICs and non-Western countries (see Table 3), which is in line with previous research (Tong et al., 2023). This could account for the larger sample sizes found in LMIC trials. Group interventions may indeed be more attractive in LMIC settings, where mental health professionals are typically scarce (approximately 1.55 per 10,000 individuals; Rathod et al., 2017). We found that guided self-help, which includes digital interventions, was underrepresented in LMICs (9.2%; vs. 17.2% in high-income countries). The ability to reach underserved populations has been named as a core advantage of guided self-help formats, especially when delivered digitally, and we know that such treatments can be effective in LMICs (Karyotaki et al., 2023; Kim et al., 2023). Further research may help to identify potential barriers in the implementation of guided self-help in such regions. This could include a lack of resources for software development and clinical evaluation on the provider side, as well as limited accessibility of the internet or other distal services among patients. Finally, it is important to note that almost all the LMIC trials included in this review were conducted in middle-income economies, whereas only 0.4% came from low-income countries. This is a woefully small number, considering that more than 700 million people live in such regions (World Bank, 2024b). However, at least in the case of depression, we found some evidence that group psychotherapy can be successfully implemented and evaluated in a low-income country ($g = 1.04$; Bolton et al., 2003; Nakimuli-Mpungu et al., 2015, 2020; see Table 4).

Increasing Psychotherapy's Public Health Impact

Our study included more than 1,000 randomized trials with roughly 86,000 patients. Solid numbers are hard to come by, but a recent review estimated that the median cost of recruiting one patient for an RCT is 409 U.S. dollars (USD; Speich et al., 2018). This would mean that more than $35 million USD had to be spent just to enroll the patients we analyzed here. This number underlines the enormous societal investment in psychological treatment research, but it pales compared to the cost of mental illness itself, which globally adds up to $4.7 trillion USD per year (Arias et al., 2022). Our meta-analysis is not the first to show that psychological interventions are an effective treatment for a range of mental health problems. Evidence-based psychological treatments are now an established part of many health care systems, and the number of patients who receive them has increased (Connolly Gibbons et al., 2011; Lipson et al., 2019; Marcus & Olfson, 2010). This raises the question of whether rising treatment rates have led to a drop in the prevalence of mental disorders, which does not appear to be the case (de Graaf et al., 2012; Jacobi et al., 2014; Kessler et al., 2005; Ormel et al., 2019, 2022). In the context of depression, Ormel et al. (2022) called this the "treatment-prevalence paradox."

Several approaches have been discussed to enhance the impact of interventions on a global scale. First, even in countries with highly developed health care systems, the majority of individuals who suffer from mental disorders do not receive minimally adequate treatment (Alonso et al., 2018; Evans-Lacko et al., 2018; Mack et al., 2014; P. S. Wang et al., 2007). This treatment gap is even worse in LMICs (Alonso et al., 2018; Evans-Lacko et al., 2018). Most of the increase in treatment coverage may also be attributable to pharmacotherapies (Ormel et al., 2019). For depression, it has been found that stand-alone pharmacotherapy and psychotherapy are similarly effective as an acute treatment, but that psychological treatment is more effective in the long run (Cuijpers, Noma, et al., 2020; Driessen et al., 2020; Furukawa et al., 2021) and that pharmacotherapy may be less suited for patients in primary care (Arroll et al., 2023). As mentioned, guided self-help interventions have been discussed as a way to improve the uptake of evidence-based psychological treatment, for example, through the internet

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(Andersson & Titov, 2014). This approach has been found to be effective for a range of mental disorders (Andersson, 2016; Ebert et al., 2019; M. Wang et al., 2023), and it does not seem to be inferior to existing face-to-face therapies (Hedman-Lagerlöf et al., 2023). Other approaches to increase access to evidence-based treatment are task-sharing (Hoeft et al., 2018; Karyotaki et al., 2022) or peer support interventions (Smit et al., 2023; https://metapsy.org/database/peer-support).

The prevention of mental disorders has also received more attention in the past 2 decades (Mendelson & Eaton, 2018; Papola, Barbui, et al., 2024). There is evidence that mental disorders can be prevented through psychological interventions, but more research is needed to understand their long-term benefits (Cuijpers, Miguel, et al., 2021; Ormel et al., 2019; Reins et al., 2021). Recent findings suggest that universal prevention may not be the method of choice and that prevention should instead focus on individuals who are already at risk (Cuijpers, 2022; Harvey et al., 2023; Kuyken et al., 2022).

Finally, one should also keep in mind that, despite decades of research, the efficacy of existing treatments is still limited. The NNTs we found in this meta-analysis exemplify this: even for the most effective interventions, compared to inactive controls, at least three patients need to receive the treatment to generate one additional case of improvement. It should be noted that this effect may still be overestimated. For most mental health problems, we found lower point estimates when only low-risk-of-bias studies were considered and maybe there are unknown biases that this analysis did not control for. We also saw that, for many indications, wait-lists still dominate as the comparator. As mentioned in the introduction, wait-lists are often considered one of the weakest control groups, and they might inflate treatment effects (Furukawa et al., 2014; Mohr et al., 2009, 2014). In the future, more realistic comparisons are needed to ensure that psychological treatments pass a "severe test" (Harrer et al., 2023; Mayo, 2005).

In the past decade, there has also been renewed interest in personalizing psychotherapeutic treatments (Cohen et al., 2021). This includes the use of, for example, machine learning approaches (Kessler et al., 2019; Rubel et al., 2020; Schwartz et al., 2021) and sensor technology (Baumeister & Montag, 2019; Mohr et al., 2017) to determine who benefits most from a specific treatment and when. Whether these innovations will reduce the global disease burden of mental disorders remains an open question. Potentially, mental health researchers may also need to accept that there is a natural limit to the benefits that a one-time psychological intervention can have in the life of patients. This could also mean that societal, environmental, and cultural determinants may gain an importance in mental health care research within the coming decades, especially in the field of prevention (Ahuvia & Schleider, 2023; Cuijpers, Miguel, Ciharova, et al., 2023; Dodge et al., 2024; Kumar et al., 2023; C. Lund et al., 2018).

Limitations

Limitations of This Study

In this study, our focus was to examine several "high-level" patterns in psychotherapy research over the past 50 years. Although we provide a fairly detailed overview of treatment effects across various mental health problems, we are aware that psychotherapy research is a large and multifaceted field. This large synthesis could not address every possible question nor could it provide the level of granular detail some may have desired. We did, for example, restrict the present analysis to adults, whereas trials in children and adolescents were excluded. There are existing databases in the Metapsy infrastructure for this target group (Cuijpers, Miguel, Harrer, Plessen, et al., 2023), which could be examined in future studies. We also focused on posttest effects only and did not study other potentially relevant outcomes, such as quality of life or treatment acceptability. While we did examine differences in the mean number of sessions, we did not analyze individually for each indication if intervention length moderates the treatment effect. For depression, there is evidence that more treatment sessions are not related to better effects if confounding variables are controlled for (Ciharova et al., 2024; Cuijpers et al., 2013). However, future studies could employ the Metapsy infrastructure to determine the robustness of this finding and if it generalizes to other mental health problems as well. Furthermore, although we did present effects for specific treatment formats and comparators, we did not conduct an in-depth analysis of their relative benefits. As mentioned in the Method section, network meta-analytic approaches could be helpful to address this research question and have been used for this purpose in the past (Cuijpers, Noma, et al., 2020; Cuijpers, Quero, Noma, et al., 2021; Mc Glanaghy et al., 2021; Papola et al., 2022, 2023; Papola, Miguel, et al., 2024). Moreover, our synthesis is based on aggregate data, which means that participant-level moderators cannot be directly examined. Our analysis could be supplemented with individual participant data in the future to examine how much treatment effects vary not only across intervention formats, comparators, and world regions but also for specific patients (Berlin et al., 2002; Fisher et al., 2017). Another limitation is that risk of bias ratings were not performed consistently across all indications, with some databases using Version 1 of the Cochrane risk of bias tool, and others employing the latest version. We plan to unify these ratings in the future so that all databases use the newest version and apply the same criteria for judging the different RoB domains. Moreover, only older searches were available for the problem gambling, psychosis, and prolonged grief databases at the time of our analysis. Results for these mental health problems should therefore be interpreted with caution. Updates of these databases are currently in progress and will be released on the Metapsy infrastructure by the end of 2024.

Finally, we also want to mention some general limitations associated with the scope and search methodology of the databases. For example, not all databases included in the Metapsy infrastructure currently include a systematic gray literature search, and some are restricted to a few selected languages (English, German, Dutch, Spanish). Some of these restrictions are deliberate; for instance, in recent updates of the depression psychotherapy database, dissertations were excluded as gray literature because they typically include small, underpowered trials and have not been peer-reviewed (Cuijpers & Karyotaki, 2019). Nevertheless, it is important to keep such limitations in mind when interpreting our findings, as well as when interpreting the evidence compiled by MARDs in general. Especially for LMICs and non-Western countries, language restrictions could mean that some potentially eligible trials are missed. There is meta-epidemiological evidence that, in biomedical contexts,

the exclusion of non-English literature is unlikely to have a substantial impact on the conclusions of meta-analytic reviews (Nussbaumer-Streit et al., 2020). Nevertheless, some of our analyses could have benefitted from a larger pool of studies. For BPD, problem gambling, GAD, prolonged grief, specific phobia, and SAD, no lower and middle-income category contained more than five studies, and our findings should be viewed in light of this limitation. It is possible that, with greater statistical power, significantly higher effects in LMICs and non-Western countries would have emerged more universally—but more evidence is required to confirm this. Due to low power, our study may have also missed indications for which psychotherapy is, in fact, less efficacious in LMIC and non-Western regions, even though we currently find no indications for this.

Limitations of MARDs

We have described the benefits of MARDs in some depth, but it is important to stress that they are certainly not a panacea. Developing an infrastructure like the one of the Metapsy initiative demands considerable resources, and its maintenance is even more labor-intensive. Developers of MARDs need to be aware that a dedicated team of researchers is required to ensure that databases are regularly updated and harmonized and that these human resources will continue to be needed in the future. This issue also extends to the technical infrastructure, which requires that individuals skilled in web development and statistical computing are available. We will discuss some long-term strategies to mitigate this problem later.

Software tools provided as part of the MARD infrastructure may also be a double-edged sword. On the one hand, they provide a real chance to make up-to-date meta-analytic evidence more accessible to those who profit from it. On the other hand, these meta-analysis tools try to simplify something that is inherently complex. There is a "law" that pertains to all statistical software development: Tools that try to facilitate a method for a broader audience also increase the chance that it will be misused (Bland & Altman, 1988; Sahu, 2016). There is indeed a risk that meta-analytic GUIs could foster statistical "cookbookery" (Box, 1976) or "cargo-cult" science (Feynman, 1998), where users follow a certain approach because the tool implements it, not out of an understanding of the underlying methodology. This problem is particularly acute in policymaking: Evidence generated "on the spot" using statistical tools in MARDs could lead to inappropriate treatment recommendations if important contextual information or robustness checks are omitted. It is important to stress that MARDs do not obliterate the need for methodological and content expertise within synthesis projects or for further peer review.

In the Metapsy initiative, we tried to limit the potential of misuse by tailoring the "researcher degrees of freedom" (Wicherts et al., 2016) to the intended target group. The statistical packages we developed allow expert users to apply a broad range of methods and to easily deviate from default settings. The GUIs are more restricted and preset in their functionality, especially the ones for patients and other stakeholders. Another measure to reduce misuse is the increased reproducibility of findings based on the MARD infrastructure. PDF reports generated by the meta-analysis tools will document all user-selected settings that lead to the reported result, as well as links to the versioned database. This enables other researchers to assess the credibility of findings, and it also allows them to check if results might hinge on very specific methodological decisions. Similar checks are also possible if R code based on the metapsyData and metapsyTools package is used to produce a meta-analysis. To minimize "post hoc" analyses, users may also submit a time-stamped research plan to the Metapsy preregistration directory (https://metapsy.org/registrations). Naturally, this does not eliminate the potential for questionable research practices, but it does provide the research community with powerful ways to assess the robustness of claims put forward using the MARD.

Finally, another potential limitation is that MARDs are labeled as "meta-analytic." This title puts a strong emphasis on quantitative outcomes that can be combined in meta-analyses, but there are also many qualitative aspects that can play an important role in research synthesis (e.g., patient feedback, treatment characteristics, or side effects). In fact, the Metapsy MARD also includes many of such characteristics, which are then categorized according to a unified taxonomy (see, e.g., our treatment taxonomy in Supplemental Material S2). Despite their name, we believe that MARDs are not necessarily inapplicable to more qualitative types of research. In this case, they could be used to compile and systematize existing evidence, as well as to provide a quantitative synthesis of bibliometric information and study features. If such MARDs are regularly updated, this would greatly improve the ease at which a "metasynthesis" and "mega-synthesis" (Bennett et al., 2023; S. Liu & Almeida, 2023) of an entire research domain can be conducted.

Establishing MARDs in Psychology

Despite these limitations, we think there is much to gain from MARDs. The present study exemplifies this: Using the Metapsy infrastructure, we conducted the probably most comprehensive meta-analysis in psychotherapy research to date, and with relative ease. Some systemic changes may be needed to establish MARDs on a broader scale. One aspect is that funders still deprioritize research software development as something to be done "on top" of existing investigations (Knowles et al., 2021; Nowogrodzki, 2019; Strasser et al., 2022). This neglects the fact that open-source research tools cannot be developed for free and that they require continuous maintenance. Despite their crucial importance, the academic system in general does not give enough credit to researchers who invest time and energy into open-source projects. For MARDs, this problem pertains both to those who curate databases, as well as to researchers who develop and maintain the necessary technical infrastructure. Strasser et al. (2022) recently emphasized that the development of research software should be recognized as unique and important scholarly output, which also entails promoting this research branch as an academic profession in its own right. We believe that this also extends to psychology: Establishing an MARD requires individuals with both subject expertise and technical knowledge, and we should incentivize psychologists who want to specialize in open software development as part of their academic career. The professionalization of open science necessitates a shift in funding policies (Barker & Katz, 2022) and a change in researchers' mindset toward long-term sustainability. The MARD concept offers a valuable framework for achieving this.

Conclusions

Our comprehensive synthesis shows that psychological treatments are effective across various mental health problems, encompassing a multitude of evidence-supported formats. High-income Western

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countries are strongly overrepresented in the current evidence, but their dominance in the field is decreasing. A rising number of trials confirm that psychotherapies are also effective in lower income countries and in non-Western cultures. Psychological intervention thus remains an essential tool to address the burden of mental illness worldwide.

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