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The Immediate Effect of a Brief Energy Psychology Intervention (Emotional Freedom Techniques) on Specific Phobias: A Pilot Study

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Background: Specific phobia is one of the most prevalent anxiety disorders. Emotional Freedom Techniques (EFT) has been shown to improve anxiety symptoms; however, their application to specific phobias has received limited attention.

Objective: This pilot study examined whether EFT, a brief exposure therapy that combines cognitive and somatic elements, had an immediate effect on the reduction of anxiety and behavior associated with specific phobias.

Design: The study utilized a crossover design with participants randomly assigned to either diaphragmatic breathing or EFT as the first treatment.

Setting: The study was conducted at a regional university in the Southwestern United States.

Participants: Twenty-two students meeting criteria for a phobic response to a specific stimulus (≥8 on an 11-point subjective units of distress scale).

Intervention: Participants completed a total of five two-minute rounds in each treatment intervention.

Outcome Measures: Study measures included a behavioral approach test (BAT), Subjective Units of Distress Scale (SUDS), and Beck Anxiety Inventory (BAI).

Results: Emotional Freedom Techniques significantly reduced phobia-related anxiety (BAI $P = .042$; SUDS $P = .002$) and ability to approach the feared stimulus (BAT $P = .046$) whether presented as an initial treatment or following diaphragmatic breathing. When presented as the initial treatment, the effects of EFT remained through the presentation of the comparison intervention.

Conclusions: The efficacy of EFT in treating specific phobias demonstrated in several earlier studies is corroborated by the current investigation. Comparison studies between EFT and the most effective established therapies for treating specific phobias are recommended.

Key words: specific phobias, energy psychology, Emotional Freedom Techniques (EFT), anxiety, exposure treatment

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INTRODUCTION

Specific phobia is the most prevalent anxiety disorder both within the United States and in other countries.[1-4] A specific phobia is characterized by a persistent and excessive unreasonable fear in the presence of, or in the anticipated presence of, a specific object, or situation. The *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition* (*DSM-IV*) recognizes four primary subtypes of specific phobias: animals (eg, snakes), natural environment (eg, heights), situational (eg, flying), blood-injection-injury (eg, injections, dentist), and an "other" category for phobias that do not fit in one of the four subtypes.[5]

Despite the widespread prevalence, it is the disorder for which individuals are least likely to seek treatment[4,6] even though it is an easily treated disorder. Two recent reviews found exposure-based treatments, especially in vivo exposure (having the patient come into direct contact with the feared stimulus), were very effective.[7,8] However, it is unclear in most of the reviewed studies how many individuals dropped out or did not enter a study due to the intense fear of being exposed to the feared stimulus.[8] In a survey of persons meeting clinical criteria for specific phobias, a greater preference and lower refusal rate for virtual reality over in vivo exposure was found with fear of confronting the feared stimulus as the most frequent reason given.[9] In addition, the ability to implement therapist-directed exposure treatments, especially those involving in vivo demonstrations, in a clinical setting limits its widespread adoption. Although several alternate treatment approaches, for example, cognitive approaches or virtual exposure, have been tried in treating specific phobias, they are not as effective as in vivo exposure. A recent review found positive results for One-Session Treatment (OST) of specific phobias.[10] The OST technique employs hierarchical exposure,

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Portions of this data were presented at Energy Psychology Conference-International 2001, San Diego, CA, and the Sixth Annual Energy Psychology Conference, 2004, Toronto, Canada.

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participant modeling, cognitive intervention, and reinforcement in a single session of up to three hours. However, due to the intensity of the intervention, a sufficient degree of participant motivation is required. Therefore, exploration of new treatments is still needed.

Energy psychology techniques have been proposed as an alternate treatment for anxiety disorders. The most widely used form of energy psychology is the Emotional Freedom Techniques (EFT).[11,12] EFT was developed by Gary Craig as an abbreviation of the methods used in Thought Field Therapy, an earlier Energy Psychology method that used elaborate diagnostic and treatment protocols.[13] EFT can be administered by a therapist or taught to individuals for self-application. The technique employs brief forms of certain components of other therapies that have demonstrated efficacy, such as cognitive restructuring and exposure; however, it also includes a somatic component. The somatic component involves tapping on prescribed acupuncture points during the process. As described in Traditional Chinese Medicine, the acupuncture points used are situated on or near the endpoints of specific meridians or energy pathways in the body. It is this use of "energy meridians" that Gary Craig and other proponents of EFT attribute as one of the primary mechanisms underlying the method's effectiveness.[14] Support for this contention was demonstrated in a recent study that found the stimulation of acupuncture points by pressure alone, without using needles, was as efficacious as needling in a randomized controlled trial.[15] Hui and colleagues[16] found acupuncture to send fear-dampening signals directly to the amygdala, the structure in the limbic system that scans the environment for threats.

Recent studies examining EFT have found evidence for EFT's ability to reduce psychological distress symptoms such as test anxiety, general anxiety, depression, and trauma.[17-24] Wells and colleagues,[25] for instance, examined the effect of a single EFT session on specific phobia of small animals. In this study 35 individuals meeting *DSM-IV* criteria for specific animal phobia were randomly assigned to either a 30-minute EFT or diaphragmatic breathing session. The EFT treatment produced an immediate improvement in behavioral and subjective distress measures, but not in pulse rate. Twenty-one (60%) of the sample completed a follow-up assessment six to nine months after the intervention. Improvements in the behavioral measure were still present at follow-up, even showing a slight increase from the posttest. There was also evidence that the improvements in the subjective distress measures were maintained at follow-up in that, although they were lower than the posttest values, they did not return to baseline levels. However, given the declines in improvement on the subjective distress measures, the superiority of EFT over diaphragmatic breathing had dissipated somewhat at the follow-up point. The authors attribute the lack of statistical significance between the two treatment conditions in part to the small sample size.

The purpose of the present study was to compare the immediate effectiveness of a single session of EFT with that of a comparison condition, diaphragmatic breathing, in the reduction of anxiety of specific phobias. Diaphragmatic breathing was chosen as the comparison treatment, as it has been used both as a stand-alone treatment as well as a component of interventions designed for stress management and to reduce anxiety.[26,27] Breathing therapies are commonly used by healthcare practitioners to reduce tension and arousal, as well as to treat specific symptoms and disorders.[28] The present study was designed as a partial replication of the Wells study.

METHOD

Participants

Participants were 22 volunteers recruited from a mass survey of students in undergraduate Psychology classes at a regional university in south Texas. More than half of the sample was female (N = 15, 68%) with an average age of 20.8 years old. Participants ethnic backgrounds included Hispanic (N = 16, 73%), in addition to Caucasian (N = 5, 23%), and other (N = 1, 4%). The inclusion criterion for this study was a phobic response, equal to or more than 8 on an 11-point subjective units of distress scale (SUDS) to a specific stimulus (described below). Phobias included fear of heights (n = 12), snakes (n = 5), cockroaches (n = 2), darkness (n = 2), and syringes (n = 1). Participants with a phobia that could not be tested directly, for example, fear of flying, were excluded. Although a formal DSM-IV diagnostic interview for specific phobias was not conducted; the SUDS cutoff score was chosen to indicate that the participant had a noticeable phobic response to one of the subtypes of specific phobias. All participants received a detailed explanation of the study and provided informed consent to participate. There were no dropouts or adverse events in the course of the study.

Measures

Subjective Units of Distress Scale. A list of six potential phobic situations and objects that could be behaviorally tested was created. The situations/objects were elevators, enclosed spaces, heights, public speaking, small animals/insects, and other anxiety-provoking stimuli that participants self-identified. Participants responded to each of these stimuli on an 11-point scale ranging from 0 (no anxiety–would not avoid it) to 10 (extremely anxious–would avoid it). This widely used scale is commonly referred to as the SUDS popularized by Joseph Wolpe's work in systematic desensitization.[29] As described above, a score equal to or greater than 8 on one of the six stimuli qualified the participant for inclusion in the study.

Beck Anxiety Inventory (BAI). The BAI[30-32] is a widely used, well-validated measure of anxiety. The 21-item measure assesses physiological and cognitive symptoms of anxiety on four-point Likert scale ranging from 0 (not at all) to 3 (severe). Responses are summed to create a total anxiety score ranging from 0 to 63. Total scores distinguish between minimal (0-7), mild (8-15), moderate (16-25), and severe anxiety (26-63). The instructions were modified to apply to the identified phobic situation, "how much are you bothered by each symptom when thinking about being in the feared situation?"

Behavioral Approach Test (BAT). The BAT is a commonly used behavioral assessment for specific phobias and a popular

objective measure of clinical progress following treatment such as exposure therapy.[7,33] Participants were assessed on their ability to approach the feared stimulus without experiencing a SUDS level of equal to or more than 5. To assess approach, the feared stimulus (eg, snake, cockroach) was presented and the proportion of comfortable distance (eg, feet) from the stimulus was calculated with 100% representing the closest distance to the phobic stimulus. In other words, a higher percentage indicates a less phobic response or ability to get closer to the feared stimulus. The approach test varied for each phobic stimulus. In the test for fear of heights participants were taken to the university stadium, which contains 38 bleachers. Participants were asked to go up the bleachers next to the outside guardrail, where they could clearly notice the height. The approach test for this particular phobia ranged from 1 bleacher (3%) to 38 bleachers (100%). The snake phobia approach test was conducted in the university serpentarium with an observation room containing 20 terrariums with live rattlesnakes. The approach test for snake phobia ranged from being no less than seven feet from the observation room (14%) to being inside the observation room, two feet away from the snakes (100%). In testing the darkness phobia, the approach test was done in an adjacent office with no light. The approach test ranged from walking toward the dark room but stopping before standing in front of the closed door (14%) to being inside the dark room, with the door completely closed for at least five seconds (100%). The approach test for the injections phobia ranged from seeing the researcher (sitting approximately five feet away) hold a syringe inside the plastic package (14%) to seeing the researcher simulate an injection (rubbing alcohol on arm and placing the needle right next to the arm; 100%). The approach test for phobia of cockroaches was done in an adjacent office where a live cockroach was kept in a jar. The test ranged from standing three feet from the jar (20%) to holding the jar and opening the lid (100%).

Procedure

The present study utilized a crossover design with participants randomly assigned to either breathing relaxation or EFT as the first treatment. Half of the participants received the breathing relaxation treatment first followed by EFT, and the other half were assigned to receive EFT first followed by breathing.

The anxiety intervention focused on the specific phobic stimulus identified by the participant. As described above, the study measures (SUDS, BAI) and intervention were conducted in a separate area, adjacent to the location of the approach test. Participants received the intervention individually or in pairs. The study self-report measures and approach test were conducted at baseline and following each intervention.

Treatment Intervention

The treatment intervention was provided by the first author who was a Master's level graduate student in counseling psychology under the supervision of a licensed psychologist (third author). The interventionist was trained in and utilized both treatments as part of her supervised clinical practice in the university counseling center. Although the intervention was delivered under the supervision of a licensed psychologist, no specific treatment fidelity measures were collected. Participants completed a total of five rounds (described below) in each treatment intervention. Each treatment round was approximately 2 minutes, resulting in a 10-minute treatment for each intervention. In both treatment conditions participants were instructed to focus on the fear while practicing either EFT or diaphragmatic breathing. In addition, the intervention took place in proximity to the feared stimulus. For example, the intervention for fear of heights was conducted at the bleachers, while the intervention for the fear of snakes was conducted in an area adjacent the observation room in the serpentarium. After each round of treatment, participants were asked to assess their anxiety level with a SUDS reading while thinking about being in the feared situation. The last SUDS reading after round 5 was considered the posttest.

Diaphragmatic Breathing. Diaphragmatic breathing, involving the use of the diaphragm, is a standard procedure that has been used for many years to reduce anxiety. For the present study, a round of diaphragmatic breathing consisted of three deep breaths, inhaling for a count of 4, holding for a count of 2, and exhaling for a count of 4.[34]

EFT. The EFT technique has both cognitive and somatic elements. The cognitive component pairs thinking about being in the feared situation with a self-acceptance statement, while the somatic component of EFT involves tapping specific points on the body with the tips of the index and middle fingers. These points correspond to the endpoints of traditional acupuncture meridians. The present study employed a brief version of EFT[11] utilizing 8 of the 12 body points. The first point on the body, referred to as the "setup," consists of tapping on the side of the hand next to the little finger, while repeating an affirmation statement three times, for example "Even though I have this fear of heights, I deeply and completely accept myself." After the setup is complete, a "reminder phrase," such as "this fear of heights," is repeated while tapping seven times at each of the remaining seven body points. These body points include the beginning of either eyebrow, the outside corner of the eye, about one inch under either eye, under the nose in the center of the upper lip, between the lower lip and the chin, just below the end of the collarbone next to the sternum, and about four inches down from the center of either armpit. A round of EFT consisted of the self-acceptance statement and tapping the eight body points.

RESULTS

Statistical Analysis

A General Linear Model repeated-measures analysis of covariance was conducted on each of the dependent variables, SUDS,

Table 1. Baseline *t*-Test Results by Treatment Order Means and Standard Deviations

Variable	Breathing-EFT Mean ± SE	EFT-Breathing Mean ± SE	t(20)	Sig
SUDS	9.45 ± 0.82	8.91 ± 0.94	1.45	0.16
BAI	38.82 ± 13.20	31.64 ± 7.62	1.56	0.13
Approach	39.91 ± 27.86	35.55 ± 14.29	0.46	0.65

Table 2. First and Second Treatment Adjusted Posttest Means and Standard Errors by Treatment Order

Variable	Treatment Order	First Treatment Posttest Mean ± SE	Second Treatment Posttest Mean ± SE	*F* (1,19)	Sig
SUDS	Breathing-EFT	5.719 ± 0.77[a]	2.890 ± 0.74[b]	12.30	0.002
SUDS	EFT-Breathing	2.872 ± 0.77[b]	2.792 ± 0.74[b]		
BAI	Breathing-EFT	27.872 ± 3.82[a]	15.278 ± 3.75[b]	4.75	0.042
BAI	EFT-Breathing	15.946 ± 3.82[b]	11.995 ± 3.75[b]		
Approach	Breathing-EFT	51.153 ± 5.88[a]	79.255 ± 6.40[b]	4.58	0.046
Approach	EFT-Breathing	68.574 ± 5.88[c]	79.472 ± 6.40[b]		

Posthoc Tukey test a > b, $P < .001$; a > c, $P < .03$.

BAI, and BAT, controlling for the baseline value. The between-subjects variable was the order of therapy presentation (breathing first/EFT second versus EFT first/breathing second) and the within-subjects variable was time of measurement (after the first treatment, and after the second treatment). Post hoc Tukey tests were conducted on significant findings.

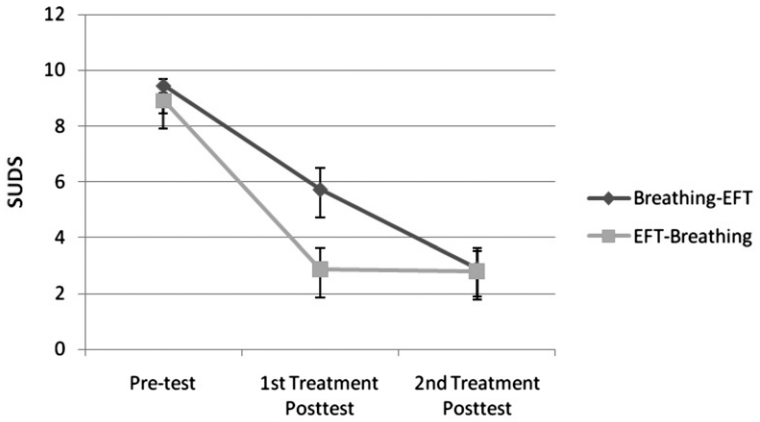
Results

The *t*-tests were conducted on the baseline SUDS, BAI, and BAT variables comparing the two treatment order groups and no significant differences were found (see Table 1). In the models examining intervention effects over time, the time by treatment order interactions were significant for each dependent variable. In the post hoc Tukey analyses the SUDS, BAI, and BAT breathing first posttest was significantly higher than the EFT presented first posttest, the EFT presented second posttest, and breathing presented second posttest (Table 2). When presented first, breathing therapy is significantly less effective in reducing subjective distress, anxiety, and ability to approach the feared stimulus than EFT. In addition, when EFT is presented following the breathing intervention a statistically significant reduction in subjective distress, anxiety, and ability to approach the feared stimulus occurs above any effect the breathing may have had. No additional reduction in subjective distress, anxiety, and ability to approach the feared stimulus occurs when breathing is presented following EFT (Figures 1, 2 and 3).

Effect sizes were calculated for the first posttest between groups for the three dependent variables. Cohen's *d* were obtained for SUDS, BAI, and BAT (1.11, 0.941, and 0.893, respectively). According to Cohen values of *d* greater than 0.80 are considered a large effect[35] indicating a large treatment effect for EFT.

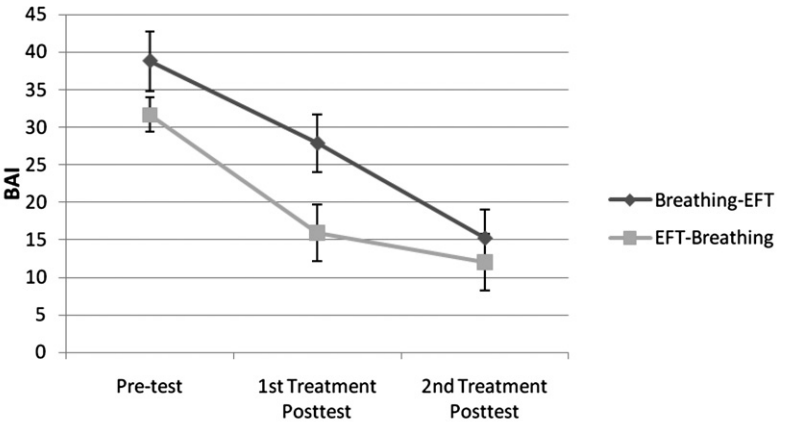
DISCUSSION

The present study demonstrated the ability of EFT to reduce anxiety related to a specific phobia in comparison to diaphragmatic breathing. EFT significantly reduced phobia-related anxiety and behavior whether presented as an initial treatment or following the comparison treatment, diaphragmatic breathing. When presented as the initial treatment, the effects of EFT remained through the presentation of a second comparison intervention. The use of a comparison condition that is often an element of many exposure, desensitization, and relaxation treatments, suggests that EFT is not merely a placebo, and therefore, worthy of additional research for the treatment of specific pho-



Pretest means are presented for comparison purposes only. The posttest means are adjusted to control for baseline values in the analysis. The difference between the pretest and posttests was not tested in the present analyses.

Figure 1. Subjective Units of Distress Scale treatment pretest and posttests adjusted means by treatment order.



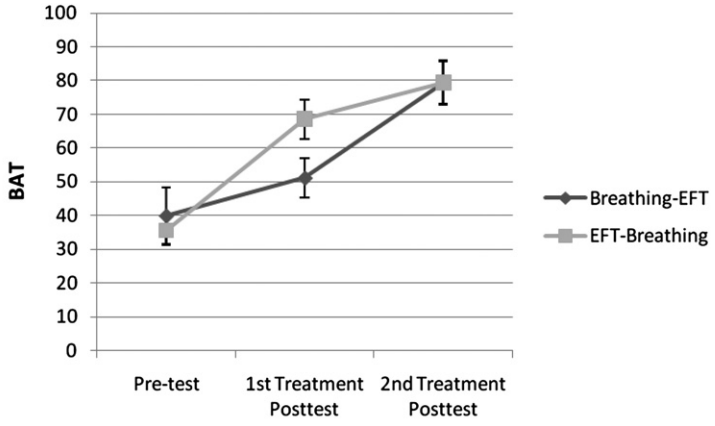
Pretest means are presented for comparison purposes only. The posttest means are adjusted to control for baseline values in the analysis. The difference between the pretest and posttests was not tested in the present analyses.

Figure 2. Beck Anxiety Inventory treatment posttests—adjusted means by treatment order.

bias. Furthermore, statistically significant effects were found with a small sample indicating a robust treatment effect.

The results of this study should be interpreted in light of the following limitations. This study is limited by the lack of a follow-up. The first author provided the treatments and collected the data. However, although it was hypothesized that EFT would yield superior results; both treatments were used by the first author in clinical practice with positive results.

The present study confirmed the immediate effect of EFT found in the Wells study. In addition, the present study examined multiple subtypes of specific phobias, not just small animal phobias as in the Wells study.[25] Although the Wells study employed a 30-minute intervention, the present study demonstrated a reduction in phobia-related anxiety and behavior following a 10-minute intervention. Given the lack of a follow-up in the present study, it is not possible to determine durability of the effects with a 10-minute intervention. Further research is needed to determine the optimal intervention period. Although the present study only examined the immediate effect of EFT on phobia-related anxiety, the Wells study on which this study was based, found some evidence for the long-term benefit of EFT in treating specific phobias. A study conducted as a partial replication of the Wells study found EFT to be superior to a supportive interview treatment and no treatment in treating small animal phobias.[36] Similar to Wells results, evidence supporting the long-term effect of EFT was found. Effect sizes obtained in these two studies, as well as the present study, indicate a large effect for EFT on specific phobias. Furthermore, the effect sizes obtained



Pretest means are presented for comparison purposes only. The posttest means are adjusted to control for baseline values in the analysis. The difference between the pretest and posttests was not tested in the present analyses.

Figure 3. Approach treatment posttests—adjusted means by treatment order.

in these studies is consistent with those obtained in a recent meta-analysis of OST of specific phobias.[10] Accordingly, these studies provide support for EFT as a well-established treatment in that the studies used a between group design comparing EFT to a psychological treatment;[37] however, the comparison treatments in these studies were not specifically designed to treat specific phobias and had relatively small sample sizes. Therefore, a comparison of EFT with other current treatments of specific phobias is needed to establish EFT as an efficacious treatment for specific phobias.

Certain elements of EFT are comparable to other specific phobia interventions, which may explain the positive results observed in this study. Namely, imaginal exposure, cognitive restructuring, and relaxation associated with tapping are all present in EFT. However, unlike other techniques, EFT is hypothesized to intervene on the body's energy system through the mechanism of tapping specific energy meridian endpoints. Theories based on the body's energy system hypothesize that energy blockages or imbalances, often due to trauma or psychological conditioning as in phobias, cause emotions to persist and block the flow of energy.[38,39] Removing the blockage and rectifying the flow of energy is believed to alleviate symptoms, such as those experienced in a phobic situation. Preliminary support for this hypothesis was found in a pilot study of EFT for claustrophobia. Changes in electrical conductance between acupuncture points were observed following a single EFT treatment.[22] Although further studies are needed to determine whether EFT is as, or more, efficacious as the existing specific phobia treatments, the contribution of tapping to the common treatment elements warrants further study. Both the present study and the Wells study utilized diaphragmatic breathing as the comparison condition as a control for EFT's ability to reduce anxiety; however, a control for the cognitive component of EFT was not used in the diaphragmatic breathing intervention in either study. Therefore, future dismantling studies of EFT should examine the contribution of both the cognitive component and tapping. In addition, verifying the unique contribution of tapping will provide further support for the principles of not just EFT, but energy psychology in general.

Clinical Implications. A strength of the present study is that positive results were observed after a very brief 10-minute EFT intervention. The single-session intervention (OST) employed to treat specific phobias can take up to three hours. Furthermore, EFT is particularly amenable to self-administration as well as instruction in group settings further enhancing its use in either the direct treatment of specific phobias or to augment an existing treatment. For example, significant improvements in psychological distress were found following both brief (four-hour workshop including two hours of self-application,[40] two weekly two-hour sessions[17]) and intensive (three-day) instruction in EFT.[23] Improvements were maintained at both 90-day[40] and six-month follow-ups.[23] In contrast to other anxiety disorders, specific phobias are particularly responsive to self-administered or minimal therapist contact interventions,[41] thus enhancing EFT's value as an intervention for this type of disorder. The short intervention time frame required and ability to administer the treatment in a group format suggests that EFT may be a cost-effective treatment for specific phobias.

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