

# The Effectiveness of Cognitive Behavioral Therapy and Emotional Freedom Techniques in Reducing Depression and Anxiety Among Adults: A Pilot Study

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## Abstract

**Context:** The World Health Organization (WHO) places major depressive disorder (MDD), or depression, as the fourth leading cause of disability worldwide. Some studies have found that cognitive behavioral therapy (CBT) represents the most superior approach in treating mild to severe symptoms. Recent literature has indicated a number of limitations to this therapeutic approach. An approach that has received increasing attention within the literature is the emotional freedom technique (EFT).

**Objective:** The current pilot study aimed to evaluate the effectiveness of CBT and EFT in the treatment of depression and comorbid anxiety.

**Design:** The research team designed a pilot study structured as a randomized, controlled trial with 2 intervention arms.

**Setting:** The study took place at Bond University in Gold Coast, Queensland, Australia.

**Participants:** Participants (n=10) were local community members who had screened positive for a primary diagnosis of MDD.

**Intervention:** Participants were randomly assigned to an 8-wk CBT or EFT treatment program, the

intervention groups. A sample of individuals from the community was assessed for comparative purposes (control group) (n=57).

**Outcome Measures:** Pre- and postintervention, all participants were interviewed using the Mini-International Neuropsychiatric Interview (MINI) 6.0, and they completed the following validated questionnaires: (1) the Beck Depression Inventory, second edition (BDI-2) and (2) the Depression, Anxiety, and Stress Scales (DASS-21).

**Results:** Findings revealed that both treatment approaches produced significant reductions in depressive symptoms, with the CBT group reporting a significant reduction postintervention, which was not maintained with time. The EFT group reported a delayed effect involving a significant reduction in symptoms at the 3- and 6-mo follow-ups only. Examination of the individual cases revealed clinically significant improvements in anxiety across both interventions.

**Conclusions:** Overall, the findings provide evidence to suggest that EFT might be an effective treatment strategy worthy of further investigation.

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The World Health Organization (WHO) places major depressive disorder (MDD), or depression, as the fourth leading cause of disability worldwide, with an estimated 350 million people of all ages suffering from the condition.<sup>1</sup> Approximately 16.20% of the world's adult population experiences at least 1 depressive episode during their lifetimes.<sup>2</sup> Outcomes of studies have shown several psychotherapies to be effective in treating MDD, with cognitive behavioral therapy (CBT) representing the most superior approach in treating mild-to-severe symptoms.<sup>3</sup>

More recent literature has indicated a number of limitations to that therapeutic approach, including limited improvements for the young and older populations.<sup>4</sup> Accordingly, a number of novel approaches have been

developed as alternative therapies for treating depression.<sup>5</sup> An approach that has received increasing attention within the literature is the emotional freedom technique (EFT), which is a group of therapies collectively referred to as *energy psychology*. Clinical EFT is a therapeutic modality based on Chinese medicine that involves manually stimulating acupressure points on the face and upper body and that has principles similar to those of Shiatsu massage.<sup>6</sup> Individuals are taught to implement a tapping technique by using 2 fingers to stimulate a pressure point while they incorporate a cognitive element that involves the individual stating a psychological concern aloud.

Randomized, controlled trials (RCTs) have consistently demonstrated the efficacy of EFT in treating adult depression. Among war veterans with comorbid posttraumatic stress disorder (PTSD), Church et al<sup>7</sup> demonstrated the efficacy of 6 sessions of EFT in promoting significant reductions in depressive symptoms, which were maintained at the 3- and 6-month follow-ups (n = 59). Another study by Church et al<sup>8</sup> found that four 90-minute, group EFT sessions were associated with significantly decreased depressive symptoms at posttest, with a mean score within the nondepressed range (n = 238).

Benor et al<sup>9</sup> conducted a double-blind, controlled trial to compare the feasibility of CBT and EFT in treating test anxiety among 15 university students. The results indicated that the interventions achieved equivalent reductions in anxiety, with EFT producing significant effects in only 2 sessions as compared with 5 sessions for the CBT program. Stapleton et al<sup>10</sup> evaluated the efficacy of CBT and EFT in the treatment of food cravings among 83 participants from the community. Both intervention groups reported significant reductions in food cravings and body mass index (BMI) posttreatment and at the 6-month follow-up. To extend the mentioned research, the current study sought to examine (1) the effectiveness of group-based CBT and EFT in treating depression and anxiety among adults, comparing the findings to a community sample; and (2) the effectiveness of both treatment approaches across time.

## Methods

### Participants

Following approval of the study by the Human Research Ethics Committee of Bond University (Gold Coast, Queensland, Australia), participants were recruited via announcements in print advertisements (eg, university notice boards and local newspapers). To be eligible, male and female participants were required to be older than 18 years and to have screened positive for MDD, as determined through administration of the Mini-International Neuropsychiatric Interview (MINI) 6.0<sup>11</sup> by a provisionally registered psychologist. Secondary comorbid conditions were expected and allowed, with those individuals having such conditions being included in the study.<sup>2</sup>

A total of 20 volunteers responded to the initial community announcements, with 17 being screened using the MINI 6.0 via telephone. Of the 17 individuals screened, all were included as meeting the specified eligibility criteria. Participants were randomly assigned, via a computerized, random-number generator system, to either an 8-week EFT (n = 6) or CBT (n = 4) program. A statistician unconnected to the study and blinded to the study's aims completed the randomization. Of the 17 participants allocated to an intervention group, 7 withdrew for personal reasons, including illness and difficulties arranging transport (Figure 1). A sample from the community was assessed for comparative purposes (n = 57). The community sample was recruited through advertisements on social media webpages of local community groups, independently of intervention participants responding to specific community announcements. Demographic and outcome data for the community group were collected and analyzed throughout the intervention period.

### Procedures

The CBT and EFT interventions involved 8 weekly sessions facilitated by trained practitioners and psychologists. A similar structure was used for the sessions in both programs, with between-session activities included in both approaches to consolidate the skills learned during sessions. Participants were contacted via e-mail at 3 and 6 months postintervention to complete the same questionnaire as was completed pre- and postintervention. The control group was invited to complete an identical questionnaire, and they were advised that the researcher was investigating emotional well-being among adults.

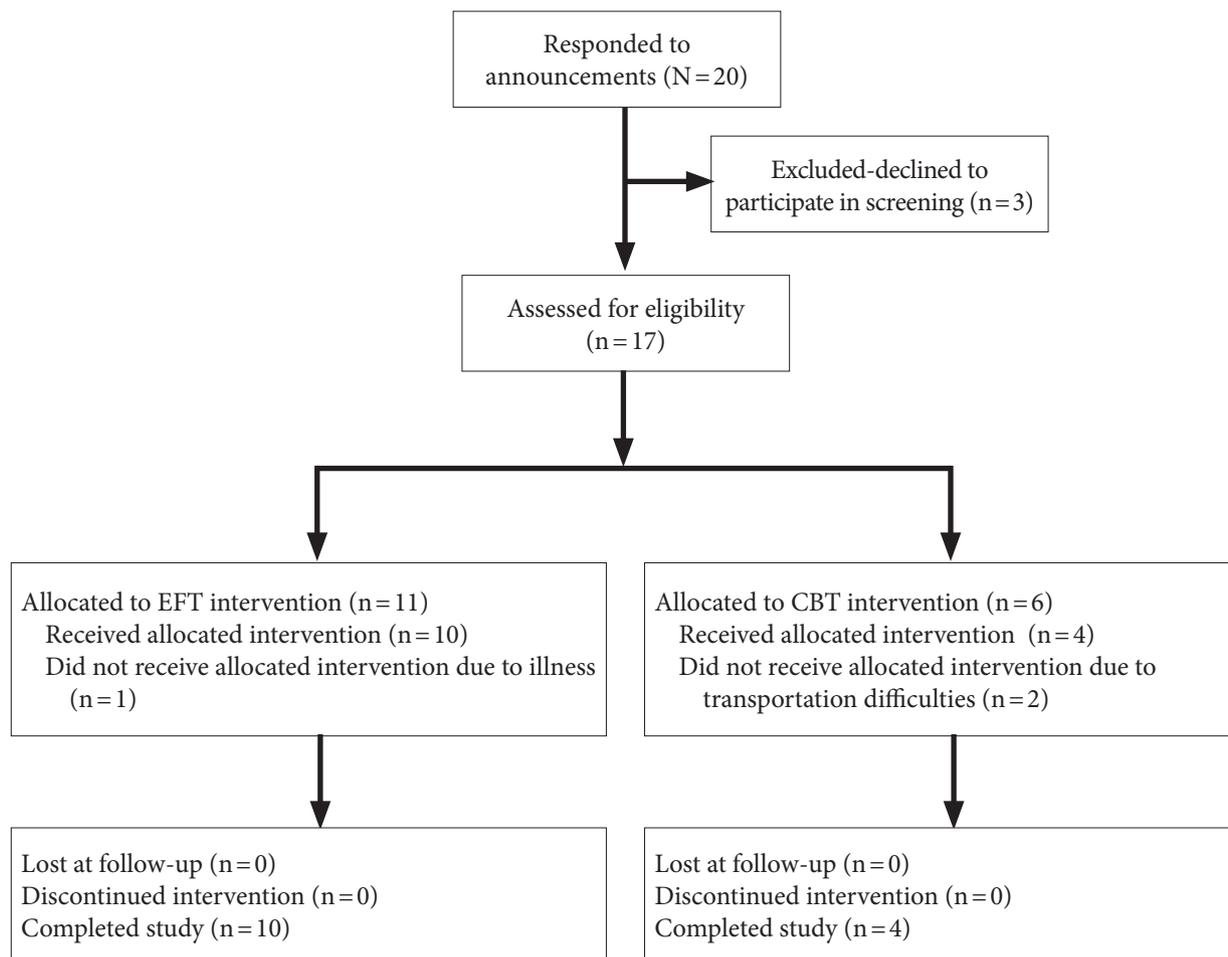
The 8 sessions for both intervention programs were structured as follows: (1) session 1—psychoeducation regarding the treatment approach, (2) session 2—behaviors involved in the maintenance of depression, (3) session 3—the thinking-feeling connection, (4) session 4—cognitive restructuring, (5) session 5—core beliefs, (6) session 6—stress and relaxation training, (7) session 7—goal setting, and (8) session 8—self-management.

### Interventions

**CBT Program.** The program was based on established and standardized protocols.<sup>12</sup> The aim of the intervention was to modify distorted thinking, dysfunctional behavior, and distressing affect by teaching participants a myriad of behavioral and cognitive strategies, such as activity scheduling in the first case and restructuring of negative automatic thoughts and/or core beliefs in the second case, to reduce depressive symptomatology.

**EFT Program.** The program was developed by the supervising researcher, together with 2 certified EFT therapists, and was based on standardized protocols.<sup>13</sup> The program was then peer reviewed. The process of EFT involved participants focusing on a distressing thought,

**Figure 1. Consort Flow Diagram**



Abbreviations: EFT, emotional freedom technique; CBT, cognitive behavioral therapy.

generating an intensity rating, initiating a setup phrase, and then completing the tapping sequence using acupressure points 1 to 7.<sup>14,15</sup> The setup phrase was focused on the emotional difficulty being experienced and involved verbalizing a statement of acceptance of the difficulty while tapping acupressure points, as per Craig's<sup>13</sup> EFT protocols.

### Outcome Measures

Participants were asked to provide demographic information for the purposes of describing the groups. Pre- and postintervention, all participants were interviewed using the MINI 6.0, and they completed the following validated questionnaires: (1) the Beck Depression Inventory, second edition (BDI-2)<sup>16</sup> and (2) the Depression, Anxiety, and Stress Scales (DASS-21).<sup>17</sup>

**Beck Depression Inventory, Second Edition.** The BDI-2 was employed to assess the frequency and severity of depressive symptoms. Items were scored on a 4-point Likert scale ranging from 0 to 3. Studies have consistently shown that the BDI-2 possesses excellent internal

consistency and test-retest reliability, and convergent validity with observer-rated measures diagnosing depression.<sup>18,19</sup>

**Depression, Anxiety, and Stress Scales.** Participants were asked to indicate on a 4-point Likert scale the extent to which they had experienced negative emotional states of depression, anxiety, and stress during the past week, using DASS-21. In the current study, the anxiety subscale scores were utilized in data analysis. The DASS-21 has been found to possess excellent reliability and validity,<sup>20</sup> adequate construct validity,<sup>21</sup> and good convergent validity across racial groups and clinical versus nonclinical samples.<sup>22</sup>

### Statistical Methods

The data were analyzed using IBM SPSS Statistics, version 22 (IBM Corp, Armonk, NY, USA). A mixed, between-within participants, 2 × 4 multivariate analysis of variance (MANOVA) was performed to determine whether the different interventions affected the dependent variables across time.

## Results

The total intervention group (ie, both the CBT and the EFT groups) consisted of 10 participants, composed of 8 women and 2 men. The community group consisted of 57 participants, including 45 women and 12 men. Table 1 shows the intervention group's and the community group's demographic information. Baseline data also revealed that the majority of members of the 2 intervention groups reported significant emotional difficulties, with 80% indicating a clinically significant depression and 60% indicating a clinically significant anxiety. The average attendance rate at sessions was 6.64 sessions for the total sample.

Multiple  $\chi^2$  analyses indicated no significant differences between groups in relation to gender, age, marital status, or educational level (Table 2).

Table 3 displays descriptive statistics for dependent variables for groups across time. At baseline, participants in the CBT and EFT groups had reported significantly higher depression and anxiety scores in comparison with the community group, as expected. As a result, the authors deemed it appropriate to use the community group for comparative purposes.

## Main Analyses

With the use of Wilks' Lambda criterion, a significant multivariate main effect, was found for the 2 intervention groups together: (1) group,  $F_{4,126} = 28.10$ ,  $P \leq .001$ , partial  $\eta^2 = 0.47$ , power = 1.00; and (2) time,  $F_{6,59} = 242.49$ ,  $P \leq .001$ , partial  $\eta^2 = 0.96$ , power = 1.00. A significant interaction between group and time was also found:  $F_{12,118} = 50.78$ ,  $P \leq .001$ , partial  $\eta^2 = 0.84$ , power = 1.00. Therefore, further analyses were focused on interaction effects.

**Depression: Group.** Univariate analyses revealed a significant interaction effect on total depression scores. Table 4 shows the significant univariate interaction effects.

Simple effects analyses for group indicated that significant differences existed between the intervention groups and the community group preintervention. At that point, no significant difference existed between the CBT and EFT groups for the depression scores ( $P = .994$ ), whereas the CBT and EFT groups had significantly higher depression scores than the community group,  $P = .018$  and  $P = .003$ , respectively.

Postintervention, significant differences were found between the 2 intervention groups for depression. The EFT group had significantly higher depression scores than the CBT group ( $P = .003$ ) and the community group ( $P < .001$ ), and the CBT group had significantly higher depression scores than the community group ( $P = .042$ ).

Simple effects analyses for group revealed that significant differences existed between groups for depression at the 3 months postintervention. The EFT group had significantly higher depression scores than the

**Table 1.** Sociodemographic Factors of the Intervention and Control Groups

	Intervention Groups % (n)	Control Group % (n)
Gender		
Women	80 (8)	78.9 (45)
Men	20 (2)	21.1 (12)
Age group, y		
18-29	40 (4)	26.3 (15)
30-39	20 (2)	19.3 (11)
40-50	40 (4)	47.4 (8)
Highest level of education		
Year 12 (high school)	30 (3)	50.9 (29)
TAFE or equivalent	30 (3)	10.5 (6)
Bachelor's degree	20 (2)	10.5 (6)
Master's degree	20 (2)	24.6 (14)
Marital status		
Single	50 (5)	19.3 (11)
Separated	10 (1)	1.8 (1)
Living with another	20 (2)	19.3 (11)
Married	20 (2)	47.4 (27)
Divorced	0 (0)	12.3 (7)
Number of people in household		
1	30 (3)	8.8 (5)
2	30 (3)	35.1 (20)
3	20 (2)	24.6 (14)
4+	20 (2)	31.6 (18)

Abbreviation: TAFE, technical and further education.

**Table 2.**  $\chi^2$  Analyses for Demographic Variables (n = 10)

Variable	df	$\chi^2$	P Value
Gender	2	4.97	.083
Age (y)	12	29.87	.103
Marital status	10	37.75	.100
Educational level	10	14.27	.161

**Table 3.** Descriptive Statistics for Dependent Variables

Variable	CBT Group (n=4) Mean ± SD	EFT Group (n=6) Mean ± SD	Control Group (n=57) Mean ± SD
DASS-21 (Baseline)	7.75 ± 4.99	6.67 ± 4.13	1.93 ± 3.16
BDI-2 (Baseline)	30.00 ± 9.20	30.67 ± 11.00	2.46 ± 3.31
DASS-21 (Post)	3.75 ± 2.36	6.17 ± 3.87	-
BDI-2 (Post)	9.50 ± 8.70	21.83 ± 14.86	-
DASS-21 (3-mo follow-up)	2.75 ± 2.75	3.83 ± 3.54	-
BDI-2 (3-mo follow-up)	11.00 ± 12.08	20.00 ± 10.88	-
DASS-21 (6-mo follow-up)	3.25 ± 4.03	5.17 ± 4.79	-
BDI-2 (6-mo follow-up)	16.00 ± 12.19	22.50 ± 12.14	-

Abbreviations: CBT, cognitive behavioral therapy; EFT, emotional freedom technique; SD, standard deviation; DASS-21, Depression, Anxiety, and Stress Scales; BDI-2, Beck Depression Inventory, second edition.

**Table 4.** Significant Univariate Interaction Effects

Depression Variable	<i>df</i>	<i>df</i> Error	<i>F</i>	<i>P</i> Value	$\eta^2$	Power
Depression	5.13	164.11	41.37	<.001	0.56	1.00
Anxiety	3.71	79.88	15.05	<.001	0.32	1.00

**Table 5.** Simple Effects Analyses for the Depression Variable

		<i>df</i>	<i>df</i> Error	<i>F</i>	<i>P</i> Value	$\eta^2$	Power
Group	Pre	2	64	144.49	<.001	0.82	1.00
	Post	2	64	35.23	<.001	0.52	1.00
	3-mo	2	64	32.51	<.001	0.50	1.00
	6-mo	2	64	47.94	<.001	0.60	1.00
Time	CBT	3	9	5.38	.021	0.64	0.78
	EFT	3	15	5.36	.010	0.52	0.85

Abbreviations: CBT, cognitive behavioral therapy; EFT, emotional freedom technique.

community group ( $P = .030$ ). However, no significant differences were found between the CBT and EFT groups ( $P = .566$ ) or the CBT group and the community group ( $P = .439$ ) for the depression scores.

At 6 months postintervention, significant differences existed between groups for the depression scores. The EFT group had significantly higher depression scores than the community group ( $P = .022$ ). However, no significant differences were found between the CBT and EFT groups ( $P = .700$ ) or the CBT group and the community group ( $P = .213$ ) for the depression scores.

**Depression: Time.** Simple effects analyses for time revealed that significant differences in depression across time were elicited for the CBT group. Its depression scores decreased significantly from pre-intervention to postintervention ( $P = .032$ ). However, that reduction was not maintained at 3 or 6 months postintervention, with  $P = .097$  and  $P = .060$ , respectively. Further, no significant

changes occurred in the depression scores for that group from postintervention to the 3- or 6-month follow-ups, with  $P = .762$  and  $P = .120$ , respectively.

For the EFT group, simple effects analyses for time revealed significant differences in depression across time. No significant change in depression scores occurred from preintervention to postintervention ( $P = .088$ ) for the EFT group. However, its depression scores decreased significantly from preintervention to 3 months ( $P = .003$ ) and 6 months ( $P = .021$ ) postintervention for the EFT participants. Moreover, no significant changes in the depression scores occurred from postintervention to the 3 and 6 months postintervention, with  $P = .508$  and  $P = .848$ , respectively. Table 3 demonstrates clinically valid changes in scores for the mean depression scores from pretreatment to the 6 months postintervention for both treatment groups. Table 5 shows the simple effects analyses in relation to depression.

**Table 6.** Simple Effects Analyses for the Anxiety Variable

		<i>df</i>	<i>df</i> Error	<i>F</i>	<i>P</i> Value	$\eta^2$	Power
Group	Pre	2	64	10.24	<.001	0.24	1.00
	Post	2	64	5.16	.008	0.14	0.81
	3-mo	2	64	1.05	.355	0.03	0.23
	6-mo	2	64	2.69	.076	0.08	0.51
Time	CBT	3	9	5.75	.024	0.66	0.76
	EFT	3	15	1.03	.388	0.17	0.13

Abbreviations: CBT, cognitive behavioral therapy; EFT, emotional freedom technique.

**Table 7.** Counts per Diagnoses of Participants in the CBT and EFT Groups at Pre- and Postintervention

Diagnosis	CBT		EFT	
	Pre	Post	Pre	Post
Major depressive disorder	4	2	6	4
Generalized anxiety disorder	3	1	4	2
Social anxiety disorder	1	0	2	1
Alcohol abuse	1	1	0	0
Panic disorder	1	1	3	1
Posttraumatic stress disorder	1	1	1	1
Agoraphobia	0	0	1	0
Obsessive-compulsive disorder	0	0	3	0
Bulimia nervosa	0	0	2	1

Abbreviations: CBT, cognitive behavioral therapy; EFT, emotional freedom technique.

**Anxiety: Group.** Univariate analyses revealed a significant interaction effect on the anxiety scores. Simple effects analyses for group indicated that significant differences existed between groups at preintervention (Table 6). At that point, no significant difference was found between the CBT and EFT groups for the anxiety scores ( $P = .871$ ), whereas the CBT and EFT groups had significantly higher anxiety scores than the community group, with  $P = .004$  and  $P = .005$ , respectively. At postintervention, significant differences existed between groups for the anxiety scores. The EFT group had significantly higher anxiety scores than the community group ( $P = .008$ ); however, no significant differences existed between the CBT and EFT groups ( $P = .473$ ) or the CBT group and the community group ( $P = .516$ ) for the anxiety scores. Simple effects analyses revealed that no significant differences were found between groups for the anxiety scores at the 3- or the 6-month follow-ups.

**Anxiety: Time.** Simple effects analyses for time revealed that significant differences in anxiety across time were elicited for the CBT group. However, pairwise comparisons indicated that no significant differences existed in the anxiety scores from preintervention to

postintervention ( $P = .104$ ) or from preintervention to 3 and 6 months postintervention, with  $P = .059$  and  $P = .093$ , respectively. In addition, no significant changes occurred in the anxiety scores from postintervention to the 3- and 6-month follow-ups, with  $P = .092$  and  $P = .604$ , respectively, for the CBT group.

For the EFT group, simple effects analyses for time indicated that no significant differences in anxiety were found across time. Although pairwise comparisons demonstrated no statistically significant differences in the anxiety scores across time for the CBT and EFT groups, descriptive statistics (Table 3) reveal clinically valid changes in anxiety scores between measurement points, including reliable change scores for the mean anxiety scores from pretreatment to 6 months postintervention for both treatment groups.

#### Clinical Diagnoses

Table 7 indicates several changes to participants' clinical diagnoses. Two of the 4 participants in the CBT group and 3 of the 6 participants in the EFT group no longer met the diagnostic criteria for MDD following completion of the intervention.

## Discussion

The results indicated that participants who received the CBT intervention exhibited a significant reduction in depressive symptoms from pre- to postintervention, whereas the EFT group did not. The results are largely consistent with previous research that has confirmed the immediate effects of CBT, such as Butler et al,<sup>3</sup> yet inconsistent with studies that have demonstrated the immediate effects of EFT.<sup>23</sup> The nonsignificant difference observed for the EFT group may be explained by the fact that participants began the intervention with more severe levels of psychopathology (Table 7).

No statistically significant reduction occurred in the anxiety scores of intervention participants from pre- to postintervention. That finding is highly inconsistent with prior studies, such as Hofmann et al.<sup>24</sup> The result is likely to have been affected by several factors, including the fact that the intervention strategies were tailored specifically to target depression, and participants were not specifically taught how to apply and generalize skills to other emotional difficulties. Nonetheless, an examination of individual cases in the present study revealed clinically valid and noteworthy improvements in anxiety scores from pre- to postintervention.

A significant reduction in depressive symptoms was observed for the EFT participants from pre-intervention to 3 and 6 months postintervention. That finding is consistent with literature that has reported the enduring treatment effects of EFT,<sup>25,26</sup> which further suggests that EFT may have a delayed effect for depressive symptoms.<sup>27,28</sup>

Treatment effects for depression exhibited by the CBT group from pre- to postintervention did not remain stable, which is largely inconsistent with previous research.<sup>29</sup> Despite participants being sent between-session reminders of upcoming sessions, attendance proved difficult with the population, which is common among depressed clients, such as Kenny and Williams.<sup>30</sup> Treatment effects for anxiety exhibited by both intervention groups were not maintained at 3 and 6 months postintervention, unlike previous studies, such as Baker and Siegel.<sup>6</sup> For the EFT group, it may be hypothesized that the active component of the intervention weakened across time, as researchers have theorized, such as Stapleton et al.<sup>28</sup>

The results indicated that a slightly greater effect was achieved by the CBT group in terms of depression scores postintervention. However, the differences between the CBT and EFT groups on depression and anxiety scores at all other measurement points were not significant. Moreover, the examination of individual cases in both intervention groups in the present study revealed clinically valid improvements in depression and anxiety scores from pre-treatment to posttreatment and the follow-up points.

The small sample size and significant dropout rate in the current study has implications for statistical power. Future replicative studies should strive to have procedures in place for assessing reasons for dropouts, in line with the

best practices and recommendations from the National Institutes of Health Behavior Change Consortium.<sup>31</sup> Practices such as the scaling up of a study for a larger group of people would be enhanced. Future studies might also seek to compare the effectiveness of CBT and EFT at individual-vs-group-delivery levels, to examine whether similar results are obtained.

## Conclusions

The current study represents the first pilot study to examine and compare the effectiveness of a gold-standard approach and a more novel approach in reducing depression and anxiety among adults. The findings of the present study have indicated that EFT may be an effective treatment strategy worthy of further investigation.

## Author Disclosure Statement

There are no known conflicts of interest relating to authors or this paper.

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