

# Is Online Treatment as Effective as In-Person Treatment? Psychological Change in Two Relationship Skills Groups

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**Abstract:** Psychotherapy has undergone a widespread change recently, with many interventions now available as wireless device apps or online courses. The current study compared the efficacy of an online program with a personal group treatment intervention. The in-person group ( $n = 37$ ) attended a 6-day workshop called Tapping Deep Intimacy that focused on the development of interpersonal skills. The online group ( $n = 37$ ) consumed the same information in the form of a 12-week online course. The content of both courses was drawn from the curriculum for Whole Energy Lifestyle, which trains participants in 12 evidence-based interpersonal and stress-reduction skills designed to reduce emotional triggering and promote health. These include mindfulness, breathwork, meditation (EcoMeditation), heart coherence, Clinical Emotional Freedom Techniques, active listening, and qigong. In both groups, depression, anxiety, and relationship satisfaction were assessed pre, post, and at 1-year follow-up. Anxiety reduced in the in-person but not the online group. Significant improvements in depression ( $p < 0.001$ ) were found in both groups, although sharper symptom declines were found in the in-person group. A 29% improvement in relationship satisfaction was found in both groups ( $p < 0.003$ ), and both maintained their gains over time. Anxiety and depression symptoms were much higher in the in-person group pretest despite similar demographic characteristics, suggesting differences in the population that uses online courses. These preliminary findings suggest that while online programs may play a role in the development of stress-reduction and interpersonal skills, it cannot be assumed that they mirror the therapeutic efficacy of in-person treatment in every dimension.

**Key Words:** Online, relationships, anxiety, depression, group therapy, WEL, EcoMeditation, Whole Energy Lifestyle, EFT

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Anxiety, depression, and relationship satisfaction are interrelated, and changes in one of these aspects can influence the others (Bodenmann and Randall, 2013). The interplay of relationships and anxiety and depression is bidirectional, where depression can lead to decreased relationship satisfaction and reduced relationship quality can lead to the development of anxiety and depression (Bodenmann and Randall, 2013). Reductions in depressive symptoms have been shown to correlate with increased relationship satisfaction (Cohen et al., 2014). This may be related to an individual's ability to offer emotional support to their partner, as one study noted that less depressed individuals were more supportive in their relationships and that supportiveness correlated with increased relationship satisfaction (Cramer, 2004, 2006). Similarly, anxiety is hypothesized to be associated with a more self-centered and less empathetic response (Davis and Oathout, 1992). A study of adolescent relationships found that those with secure attachment to their peers scored significantly lower on anxiety and depression

scores (Muris et al., 2001). Anxiety and depression have both been shown to correlate with negative experiences with close friends and romantic partners (La Greca and Harrison, 2005).

Psychological trauma has been extensively shown to influence anxiety, depression, and interpersonal relationships. Trauma symptoms (Goff et al., 2007) and posttraumatic stress disorder (PTSD; Klaric et al., 2011) have been shown to have a direct negative impact relationship satisfaction. Where one or both partners suffer from PTSD, couples therapy has been shown to be effective at reducing symptoms and improving relationship satisfaction (Monson et al., 2012). Similarly, individuals practicing mindfulness techniques have better communication, conflict resolution, and relationship satisfaction than those who do not (Barnes et al., 2007). An analysis of the clinical outcomes of couples studied in a naturalistic setting found a significant improvement in both psychological distress and relationship satisfaction (Hewison et al., 2016).

Whole Energy Lifestyle (WEL) is a manualized suite of evidence-based stress-reduction and interpersonal relationship skills, including mindfulness training, breathwork, heart coherence training, qigong, Emotional Freedom Techniques (EFTs), active listening, and meditation. It is described in a published manual (Church, 2011). Systematic reviews find the practices taught in WEL to be “evidence-based” (Chiesa and Serretti, 2009; Church, 2013a; Feinstein, 2012; Jahnke et al., 2010; Marlow et al., 2012; McCraty, 2005). Not only do they improve mental health, they regulate biology at the most fundamental levels including stress hormone synthesis and gene expression (Church et al., 2012b; Church et al., 2018; Feinstein, 2010; Feinstein and Church, 2010). The manual administers the intervention in a highly structured manner, beginning with stress-reduction practices such as heart rate variability regulation and neurofeedback (Church, 2011). It then progresses to soothing somatic practices such as yoga and qigong. From there, it engages participants in imaginal practices such as guided imagery and visualization. AQ2

Here, we relate WEL to intimate partner relationships, but WEL may also be applicable to improving social functioning in other interpersonal relations within the family, work, and social networks. There is as yet little research directly comparing interventions delivered online and similar interventions delivered in-person.

## METHODS

This study assessed changes in individuals receiving a WEL intervention online versus in person. The in-person group attended a 6-day seminar; the online group, a 12-week course. Depression and anxiety were assessed using the Hospital Anxiety and Depression Scale (HADS; Zigmond and Snaith, 1983), which has been extensively validated in individuals with either somatic or psychiatric issues in the primary care setting (Bjelland et al., 2002). Relationship satisfaction was assessed using the Relationship Assessment Scale (RAS; Hendrick et al., 1998), which has demonstrated validity when compared with similar instruments (Vaughn and Matyastik Baier, 1999), and has been validated for assessing multiple types of relationships (Renshaw et al., 2011). There does not appear to be a significant difference between data collected in person and data collected online (Meyerson and Tryon, 2003). The study design was evaluated by the Ethics Committee

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**TABLE 1.** In-Person Participant Characteristics ( $n = 37$ )

Age, mean (range)	53 (37–83)
Sex, female, n (%)	30 (81.1%)
Education, n (%)	
High school diploma	4 (10.8%)
Undergraduate degree	18 (48.6%)
Graduate degree+	15 (40.5%)
Anxiety	7.7 ± 3.9
Depression	4.5 ± 4.0
Relationship satisfaction	3.5 ± 1.2

of the National Institute for Integrative Healthcare, and all participants provided informed consent.

Participants were two self-selected convenience samples; one enrolling for an in-person group, the other for an online group. To facilitate comparisons of the demographic characteristics of individuals seeking each type of intervention, the study used matched groups rather than randomization. Subjects were assessed for depression, anxiety (HADS), and relationship satisfaction (RAS) before and after the event, as well as at 1-year follow-up. The HADS includes seven questions related to depression and seven questions related to anxiety. Each item is scored from 0 to 3, and the score is totaled. Thus, subjects can score from 0 to 21 for either anxiety or depression. The RAS includes seven questions that are answered using a five-point scale to rate satisfaction, frequency, or quality. The score is totaled and divided by seven to yield a five-point overall score of relationship satisfaction with 1 being the lowest satisfaction and 5 being the highest.

In the in-person group, participants discussed their relationship issues collectively, while using mindfulness, breathwork, EFT, and other methods to reduce stress. A group delivery method known as “Borrowing Benefits” described in *The EFT Manual* (Church, 2013b) was used, in which an individual or couple is treated while the remainder of the group simultaneously self-applies the method. The setting for the in-person group was a hotel conference room. Two hours of each day were spent on psychoeducation in common relationship problems such as communication styles and attachment theory, and 5 hours were spent performing WEL in group format. Each session began with EcoMeditation, a simple form of meditation based on evidence-based autonomic regulation methods and lacking a conceptual structure based on spirituality or religion (Groesbeck et al., 2018).

Participants in the 12-week online course had continuous access to the Tapping Deep Intimacy Web site, which contains 12 modules. These start with basic relationship concepts such as attachment theory and subpersonalities, and continue with instruction in each of the WEL techniques. Each week's lesson includes a practical skill such as active listening, EFT, or EcoMeditation. To accommodate different learning styles, weeks include written material, video, and audio. Participants are instructed to use Borrowing Benefits while watching the videos or listening to the audios. For 1 year after the program,

**TABLE 2.** Pre Versus Post ( $n = 37$ )

Score	Pretest, Mean ± SD	Posttest, Mean ± SD	Change in Mean	Z	p
Anxiety	7.7 ± 3.9	4.8 ± 2.7	2.9	-4.3	<0.001
Depression	4.5 ± 4.0	2.8 ± 2.7	1.7	-3.5	<0.001
Relationship satisfaction	3.5 ± 1.2	4.1 ± 1.0	0.6	3.6	<0.001

**TABLE 3.** Pre Versus Follow-up ( $n = 25$ )

Score	Pretest, Mean ± SD	Follow-up, Mean ± SD	Change in Mean	Z	p
HADS-a	7.7 ± 3.9	5.4 ± 3.3	2.3	-3.4	0.001
HADS-d	4.5 ± 4.0	3.5 ± 3.6	1	-2.4	0.015
RAS	3.5 ± 1.2	4.0 ± 0.9	0.5	2.1	0.035

participants in both the in-person and online group had access to a monthly live teleclass in which a volunteer participant received a relationship coaching session. WEL instruction was provided by the first author. Data analysis was conducted by the second author.

## RESULTS

### Statistical Analysis

Subject scores for HADS and RAS were compared before and after treatment and at 1-year follow-up using a Wilcoxon signed rank test.

### Participant Characteristics of In-Person Group

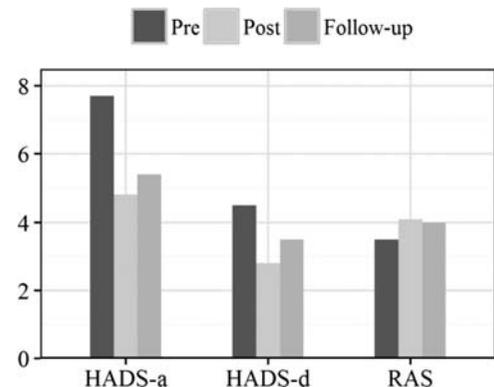
Demographic data for the 37 in-person subjects are summarized in Table 1. Subjects had a mean age of 53 years, with a range of 37 to 83 years. Most of the subjects were female (81%). Most participants had earned an undergraduate degree (48.6%), followed by those who had earned a graduate degree or higher (40.5%), with a high school diploma being the least common (10.8%).

### Pre-Post Analysis of In-Person Group

Statistically significant presession and postsession improvements were found in all three assessment scores in the in-person group (Table 2). Depression and anxiety measures decreased, while relationship satisfaction scores increased. Only one subject reported a reduction in relationship satisfaction after the workshop.

### Follow-up Analysis of In-Person Group

There were 12 subjects who could not be contacted for the 1-year follow-up, leaving 25 subjects for analysis. Subjects maintained significant improvements on all three assessments after 1 year (Table 3). The 0.6-point improvement in RAS score constitutes a 29% increase in satisfaction. Figure 1 compares pre, post, and follow-up scores for all three tests. There were no dropouts between pretest and posttest.

**FIGURE 1.** Score change for anxiety (HADS-a), depression (HADS-d), and relationship satisfaction (RAS) were maintained at follow-up.

**TABLE 4.** Online Participant Characteristics (n = 37)

Age, mean (range)	53 (36–82)
Sex, female, n (%)	33 (89.2%)
Education, n (%)	
High school diploma	4 (10.8%)
Undergraduate degree	17 (45.9%)
Graduate degree+	16 (43.2%)
Anxiety	2.6 ± 0.5
Depression	2.5 ± 0.4
Relationship satisfaction	2.7 ± 0.6

**Participant Characteristics of Online Group**

The pretest was completed by 103 participants and the posttest by 37. Demographic data for the 37 online subjects with both pretest and posttest data are summarized in Table 4. Subjects had a mean age of 53 years, with a range of 36 to 82 years. Most of the subjects were female (89.2%). Most participants had earned an undergraduate degree (45.9%), followed by those who had earned a graduate degree or higher (43.2%), with a high school diploma being the least common (10.8%). No significant difference was found at baseline on any measure between those who completed the posttest and those who did not.

**Pre-Post Analysis of Online Group**

Statistically significant pre-session and post-session improvements were found in depression and relationship satisfaction in the online group, but not in anxiety (Table 5). Depression measures decreased, whereas relationship satisfaction scores increased.

**Follow-up Analysis of Online Group**

There were seven subjects who could not be contacted for the 1-year follow-up, leaving 30 subjects for analysis. Subjects maintained significant improvements with depression and relationship satisfaction after 1 year (Table 6). The 0.5-point improvement in RAS score represents a 29% increase in relationship satisfaction. Figure 2 compares pre, post, and follow-up scores for all three tests. Of those who enrolled for the online course, 102 completed a pretest, and 37 completed a posttest. All analysis was performed on the group from which these two data points were available. No adverse events were noted in either the online or the in-person group.

**Comparisons Between Groups**

Two-way analysis of variance was used to compare changes in anxiety, depression, and relationship satisfaction between in-person and online participants across the pre-, post-, and follow-up time-points. Compared with the online group, the in-person group had higher anxiety, depression, and relationship satisfaction scores at all three time points. A main effect for the difference in anxiety levels was observed between in-person and online participants [ $F(1,202) = 102.7$ ,

**TABLE 5.** Pre Versus Post (n = 37)

Score	Pretest, Mean ± SD	Posttest, Mean ± SD	Change in Mean	Z	p
Anxiety	2.6 ± 0.5	2.6 ± 0.4	0.0003	0.2	0.8668
Depression	2.5 ± 0.4	2.2 ± 0.3	0.3	-3.1	0.0012
Relationship satisfaction	2.7 ± 0.6	3.2 ± 0.8	0.5	2.9	0.0032

**TABLE 6.** Pre Versus Follow-up (n = 30)

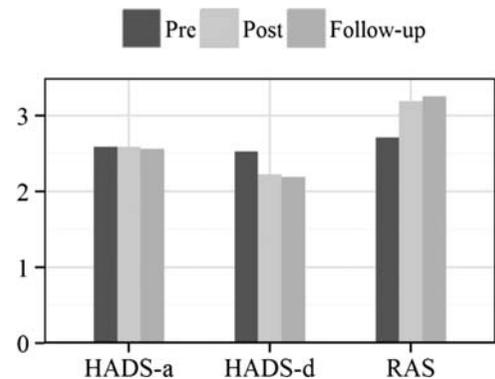
Score	Pretest, Mean ± SD	Follow-up, Mean ± SD	Change in Mean	Z	p
HADS-a	2.6 ± 0.5	2.6 ± 0.4	0.03	0.08	0.9376
HADS-d	2.5 ± 0.4	2.2 ± 0.3	0.3	-3.1	0.0012
RAS	2.7 ± 0.6	3.3 ± 0.7	0.6	2.8	0.0045

$p < 0.0001$ ], and these differences were significant at all time points [ $F(2,202) = 7.1, p < 0.01$ ]. The anxiety scores in the in-person group were significantly improved after treatment, whereas the online group experienced no significant changes in anxiety after treatment. The difference in depression was significant with higher levels in the in-person group at baseline [ $F(1,202) = 14.3, p < 0.001$ ] and both groups changed similarly over time with reductions in their scores for depression [ $F(2,202) = 1.04, p = 0.2524$ ] (Tables 2 and 5). Similarly, the difference in relationship satisfaction was significant between the two groups at pretest [ $F(1,202) = 37.0, p < 0.0001$ ] with both groups showing improved scores over time [ $F(2,202) = 0.193, p = 0.8246$ ]. Figure 3 compares pre, post, and follow-up scores for all three tests between the in-person and online groups.

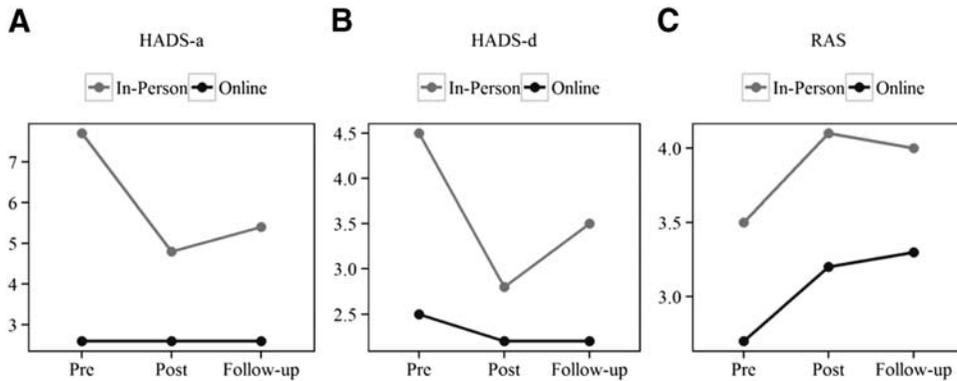
**DISCUSSION**

This study has a number of implications relevant to in-person and online treatment. Although the demographic characteristics of both groups were similar, their symptom levels at the outset were quite different. This suggests that there may be differences between populations that seek in-person treatment and those that seek online treatment. The extent of this difference was one surprising finding of this study. Clinicians cannot assume that clients presenting online are homologous with those they treat in person. Such assumptions might lead to inappropriate treatment recommendations, and a misplaced belief that online interventions are simply distant applications of in-person therapy.

Second, psychological symptom improvements were markedly better in the in-person group than the online group, suggesting that online therapeutic experiences cannot be assumed to possess the same therapeutic efficacy as in-person treatment. There may be dimensions of the in-person therapeutic encounter that cannot easily be duplicated in online environments. Brain imaging studies find that the brain processes face-to-face interactions differently than it does nonproximate interactions (Newberg and Waldman, 2017). However, the results nonetheless suggest that training in stress-reduction skills may be effective in improving relationship satisfaction regardless of whether such skills are acquired online or in-person.



**FIGURE 2.** Score change for depression (HADS-d) and relationship satisfaction (RAS) were maintained at follow-up in online participants.



**FIGURE 3.** Comparison of score changes for anxiety (HADS-a), depression (HADS-d), and relationship satisfaction (RAS) between in-person and online participants.

The suite of therapeutic approaches presented to WEL participants is intended to allow them to experience a variety of possible behavioral modifications and choose those that suit their lifestyle. This is intended to overcome the “one size fits all” approach taken by proponents of each individual element of WEL, an issue which often leads to poor patient compliance with potentially beneficial lifestyle changes. However, an experimental limitation of this approach is that it renders it impossible to calculate the relative contribution each component makes to the observed therapeutic effects. Although WEL itself as administered here is based on practices that have been found to be evidence-based, the protocol as a whole has not undergone rigorous efficacy research.

The study had a number of limitations. Participants were self-selected in both groups and were not randomized between groups. Although this yielded valuable demographic data about the characteristics of participants who seek in-person versus online therapeutic encounters, it resulted in two groups with significant differences at baseline. An extension of this study in which participants with similar characteristics are randomly assigned to groups would control for this variable. It might also include a third group that receives in-person treatment followed by extended online support. The two groups in the present study were convenience samples, and the study was performed to provide clinicians with a preliminary sense of how online group therapy might differ from in-person therapy. Further enhancements to a future design would be to match the populations of the groups both demographically and by symptom clusters on the HAD, RAS, or other instruments, as well as adding categorical diagnoses by mental health professionals.

It is also noteworthy that while there were no dropouts in the in-person group, which was meeting in a hotel room, there was a large attrition rate in the online group, with 65 of the 102 participants failing to complete the posttest. Not only may these dropouts have skewed the results, they point to the difficulty of collecting data online.

An important qualifier is that these findings are not necessarily generalizable to individual therapy sessions. The characteristics of those clients who seek group therapy might differ from those who seek individual counseling, and there are certain psychiatric diagnoses that render clients inappropriate candidates for group therapy. Also, although WEL consists of a suite of techniques, the intent of which is to allow clients to sample and then self-select those approaches most applicable to their lifestyle, this makes it impossible to determine which of the techniques produced which portion of the observed therapeutic effect. This variability is inherent in the WEL protocol. In addition, symptom changes were not assessed separately in those being treated in front of the groups (whether in in-person sessions or online teleseminars) and those witnessing the sessions. Further, in online programs, it is impossible for investigators to monitor patient compliance

in the same manner that in-person observation permits. This preliminary investigation should be regarded as a pilot, raising questions to be addressed by the next stage of research.

Further limitations include reliance on self-report rather than observer-rated diagnosis of anxiety and depression, and the nonclinical symptom scores of both groups at pretest, which may make the samples unrepresentative of the population that typically seeks treatment for clinical symptom levels. Other limitations include the small samples size in both groups and the presentation of WEL to both groups by one of the study authors, although that same characteristic also had the benefit of increasing the consistency of treatment. The effects obtained could have been due to nonspecifics present in any therapy, to the supportive nature of the group, to demand characteristics, or to spousal support.

Nonetheless, this study shows that WEL may be a valuable adjunctive therapy for couples counseling, as well as building relationship skills in individuals, and that a modest investment of time may lead to both clinically and statistically significant improvement in mental health symptoms as well as relationship satisfaction for those with high symptom levels. When delivered either online or in-person, the interpersonal skills taught in WEL may provide increases in relationship satisfaction to both individuals and couples.

## DISCLOSURE

*The first author derives income from publications and presentations on certain of the therapies evaluated in this study. The second author declares no conflict of interest.*

*This article has not been submitted elsewhere.*

## REFERENCES

- Baker AH, Siegel MA (2010) Emotional Freedom Techniques (EFT) reduces intense fears: A partial replication and extension of Wells, Polglase, Andrews, Carrington, & Baker (2003). *Energy Psychol.* 2:13–30.
- Barnes S, Brown KW, Krusemark E, Campbell WK, Rogge RD (2007) The role of mindfulness in romantic relationship satisfaction and responses to relationship stress. *J Marital Fam Ther.* 33:482–500.
- Bjelland I, Dahl AA, Haug TT, Neckelmann D (2002) The validity of the Hospital Anxiety and Depression Scale: An updated literature review. *J Psychosom Res.* 52:69–77.
- Bodenmann G, Randall AK (2013) Close relationships in psychiatric disorders. *Curr Opin Psychiatry.* 26:464–467.
- Chiesa A, Serretti A (2009) Mindfulness-based stress reduction for stress management in healthy people: A review and meta-analysis. *J Altern Complement Med.* 15: 593–600.

- Church D (2009) The effect of EFT (Emotional Freedom Techniques) on athletic performance: A randomized controlled blind trial. *Open Sports Sci J*. 2:94–99.
- Church D (2011) *The Whole Energy Lifestyle (WEL) workbook*. Santa Rosa, CA: Energy Psychology Press.
- Church D (2013a) Clinical EFT as an evidence-based practice for the treatment of psychological and physiological conditions. *Psychology*. 4:645–654.
- Church D (2013b) *The EFT manual* (3rd ed). Santa Rosa, CA: Energy Psychology Press.
- Church D, De Asis MA, Brooks AJ (2012a) Brief Group Intervention Using Emotional Freedom Techniques for Depression in College Students: A Randomized Controlled Trial. *Depress Res Treat*. 2012:257172.
- AQ5** Church D, Geronila L, Dinter I (2009) Psychological symptom change in veterans after six sessions of Emotional Freedom Techniques (EFT): An observational study. *Int J Healing Caring*. 9.
- AQ6** Church D, Hawk C, Brooks AJ, Toukolehto O, Wren M, Dinter I, Stein P (2013) Psychological trauma symptom improvement in veterans using emotional freedom techniques: A randomized controlled trial. *J Nerv Ment Dis*. 201: 153–160.
- Church D, Yount G, Brooks AJ (2012b) The effect of Emotional Freedom Techniques on stress biochemistry: A randomized controlled trial. *J Nerv Ment Dis*. 200: 891–896.
- AQ5** Church D, Yount G, Rachlin K, Fox L, Nelms J (2018) Epigenetic effects of PTSD remediation in veterans using clinical EFT (Emotional Freedom Techniques): A randomized controlled pilot study. *Am J Health Prom*. 32:112–122.
- Cohen S, Daniel O'Leary K, Foran HM, Kliem S (2014) Mechanisms of change in brief couple therapy for depression. *Behav Ther*. 45:402–417.
- Craig G, Fowlie A (1995) *Emotional freedom techniques: The manual*. Sea Ranch, CA: Gary Craig.
- Cramer D (2004) Emotional support, conflict, depression, and relationship satisfaction in a romantic partner. *J Psychol*. 138:532–542.
- Cramer D (2006) How a supportive partner may increase relationship satisfaction. *Br J Guid Counsel*. 34:117–131.
- Davis MH, Oathout HA (1992) The effect of dispositional empathy on romantic relationship behaviors: Heterosocial anxiety as a moderating influence. *Pers Soc Psychol Bull*. 18:76–83.
- Feinstein D (2012) Acupoint stimulation in treating psychological disorders: Evidence of efficacy. *Rev Gen Psychol*. 16:364–380.
- Feinstein D, Church D (2010) Modulating gene expression through psychotherapy: The contribution of non-invasive somatic interventions. *Rev Gen Psychol*. 14: 283–295.
- Goff BS, Crow JR, Reisbig AM, Hamilton S (2007) The impact of individual trauma symptoms of deployed soldiers on relationship satisfaction. *J Fam Psychol*. 21: 344–353.
- AQ5** Groesbeck G, Bach D, Stapleton P, Blickheuser K, Church D, Sims R (2018) The interrelated physiological and psychological effects of EcoMeditation: A pilot study. *J Evid Base Integr Med*. 23:2515690X18759626.
- Hendrick SS, Dicke A, Hendrick C (1998) The Relationship Assessment Scale. *J Soc Pers Relat*. 15:137–142.
- AQ5** Hewison D, Casey P, Mwamba N (2016) The effectiveness of couple therapy: Clinical outcomes in a naturalistic United Kingdom setting. *Psychotherapy*. 53:377.
- Jahnke R, Larkey L, Rogers C, Etnier J, Lin F (2010) A comprehensive review of health benefits of qigong and tai chi. *Am J Health Promot*. 24:e1–e25.
- Klaric M, Franciskovic T, Stevanovic A, Petrov B, Jonovska S, Nemicic Moro I (2011) Marital quality and relationship satisfaction in war veterans and their wives in Bosnia and Herzegovina. *Eur J Psychotraumatol*. 2. doi:10.3402/ejpt.v2i0.8077.
- La Greca AM, Harrison HM (2005) Adolescent peer relations, friendships, and romantic relationships: Do they predict social anxiety and depression? *J Clin Child Adol Psychol*. 34:49–61.
- Marlow E, Nyamathi A, Grajeda WT, Bailey N, Weber A, Younger J (2012) Nonviolent communication training and empathy in male parolees. *J Correct Health Care*. 18:8–19.
- McCarty R (2005) Enhancing emotional, social, and academic learning with heart rhythm coherence feedback. *Biofeedback*. 33:130–134.
- Meyerson P, Tryon WW (2003) Validating Internet research: A test of the psychometric equivalence of Internet and in-person samples. *Behav Res Methods Instrum Comput*. 35:614–620.
- Monson CM, Fredman SJ, Macdonald A, Pukay-Martin ND, Resick PA, Schnurr PP (2012) Effect of cognitive-behavioral couple therapy for PTSD: A randomized controlled trial. *JAMA*. 308:700–709.
- Muris P, Meesters C, van Melick M, Zwambag L (2001) Self-reported attachment style, attachment quality, and symptoms of anxiety and depression in young adolescents. *Personal Individ Differ*. 30:809–818.
- Newberg A, Waldman MR (2017) *How enlightenment changes your brain: The new science of transformation*. London: Penguin.
- Renshaw KD, McKnight P, Caska CM, Blais RK (2011) The utility of the relationship assessment scale in multiple types of relationships. *J Soc Pers Relat*. 28:435–447.
- Salas MM, Brooks AJ, Rowe JE (2011) *The immediate effect of a brief energy psychology intervention (Emotional Freedom Techniques) on specific phobias: a pilot study* (Vol. 7, pp 155–161). New York: Explore.
- Stapleton P, Church D, Sheldon T, Porter B, Carlopio C (2013) Depression symptoms improve after successful weight loss with emotional freedom techniques. *ISRN Psychiatry*. 2013:573532.
- Stapleton P, Sheldon T, Porter B (2012) Clinical benefits of Emotional Freedom Techniques on food cravings at 12-months follow-up: A randomized controlled trial. *Energy Psychol*. 4:13–24.
- Vaughn MJ, Matyastik Baier ME (1999) Reliability and validity of the relationship assessment scale. *Am J Fam Ther*. 27:137–147.
- Wells S, Polglase K, Andrews HB, Carrington P, Baker AH (2003) Evaluation of a meridian-based intervention, Emotional Freedom Techniques (EFT), for reducing specific phobias of small animals. *J Clin Psychol*. 59:943–966.
- Wolpe J (1973) *The practice of behavior therapy* (2nd ed). New York: Pergamon Press.
- Zigmond AS, Snaith RP (1983) The Hospital Anxiety and Depression Scale. *Act Psychiatr Scand*. 67:361–370.