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Eliminating Fears: An Intervention that Permanently Eliminates the Fear of Public Speaking

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This study examines the ability of a novel psychological treatment to eliminate anxiety, using fear of public speaking as a test case. The treatment was designed specifically to eliminate beliefs and de-condition stimuli that are responsible for dysfunctional behaviors and emotions. A random half of the subjects received treatment immediately while wait-listed control subjects were treated three to four weeks later. After having engaged in an actual public speaking experience, subjects' self-reported ratings showed significant reductions in fearfulness, physical sensations and cognitive difficulties often associated with speaking in public. The evidence strongly suggests that fear of public speaking was virtually eliminated and we propose that it holds promise as an intervention that might be effective in treating many other disorders. Copyright © 2006 John Wiley & Sons, Ltd.

INTRODUCTION

Several surveys indicate that Americans rank speaking in public as their number one fear (Bruskin Associates, 1973; Motley, 1988; Richmond & McCroskey, 1995). This fear can be socially debilitating, and is often cited as a primary reason why someone is unable to advance in his or her career. Fear of public speaking may be related to a more general social anxiety, but it is not coterminous with it, as many people appear to have quite specific fear of public speaking in the context of otherwise normal social relationships. Different therapeutic approaches have been developed to help people overcome or deal with such fears as public speaking. One such approach is The Lefkoe Method (TLM).

The Lefkoe Method, developed by the second author, aims to eliminate, quickly, long-held beliefs and 'de-condition' the stimuli that produce fear and other negative emotions, e.g. the fear of speaking in public. Lefkoe has discovered that the fear of public speaking is typically caused by (a) specific beliefs, such as 'Mistakes and failure are bad' and 'If I make a mistake, I'll be rejected' and (b) conditioning, such as automatically experiencing fear whenever one is, or perceives oneself to be, in a position to be criticized or judged. Two processes in TLM, the Lefkoe Belief Process and the Lefkoe Stimulus Process, are used to address fear of public speaking.

Many, if not most, psychologists contend that long-held beliefs can be totally eliminated, if at all, only after extensive time, effort, and specific retraining. TLM challenges that assumption and contends that even beliefs formed early in childhood can be permanently eliminated in a matter of minutes. The basis for this claim is thousands of clients who state that a belief that was experienced as true is no longer experienced as true and that the behavior and emotions that result from the belief are permanently eliminated. Moreover, TLM contends that emotions that result from conditioned stimuli, for example, fear that is always experienced when one makes a mistake or is rejected, can be quickly and permanently stopped

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by de-conditioning the stimuli. This also can be accomplished in a matter of minutes. Those are bold claims, but they can be empirically tested. Because of the extensive clinical experience with TLM, we have elected to test it in clinical settings rather than a laboratory. This article reports on the results of applying TLM to the reduction of fear associated with public speaking.

TLM, despite its fairly lengthy history, is not widely known, partly because no systematic attempt has ever been made to publicize it. If it can be shown to be effective in terms of scientific evidence, it has the potential to be highly useful since it is, as will be seen, a brief intervention that may be delivered even without face-to-face contact for at least some conditions.

Although the Lefkoe Belief Process (LBP) is similar in some ways to cognitive therapy approaches (CT), there are many unique aspects that distinguish it from other such approaches. First, some versions of CT attempt to change beliefs by challenging the validity of the evidence that the client uses to support them. With LBP no attempt is made to get clients to see that a current belief is wrong or not true, to see it as illogical, to accept that it does not make sense, or to reject it as self-defeating. The LBP actually validates people for forming the belief earlier in life by assisting them to realize that most people probably would have made a similar interpretation under similar circumstances. It ensures that people realize that their belief actually is one valid meaning of their earlier circumstances.

The 'evidence' that people offer for a belief usually is not the actual reason they believe it. The evidence offered usually consists of recent observations that appear to substantiate the belief. The real source of one's beliefs, the LBP assumes, is interpretations of circumstances earlier in life. Fundamental beliefs about one's self and life are usually formed in childhood. After a belief has been formed, however, one acts consistently with it, thereby producing 'current evidence' for the already-existing belief. In other words, life becomes a self-fulfilling prophecy. Because the evidence one presents to validate one's beliefs usually is a consequence of the beliefs, not its source, challenging the validity of that evidence is not the most effective way to eliminate them.

A third element that distinguishes LBP from some versions of CT has to do with getting the client to agree to act consistently with an alternative belief to test its possible validity. Because the current belief is totally eliminated by doing the LBP, one has no need to try to act differently when one goes back 'into life'; one's behavior changes naturally and effortlessly once the belief is gone.

Still another distinction between the LBP and many cognitive approaches is that the latter frequently are a tool for the client, whereas the former is a tool for the facilitator. Cognitive approaches assist clients to think more rationally in order to act more rationally in the face of strong emotions such as fear, anger, depression, hostility etc. The LBP is used by the facilitator to assist clients in eliminating the beliefs that produce such emotions. When these emotions stop after the beliefs that give rise to them are eliminated, there is no longer a need for a tool for clients to deal with them more effectively.

Finally, the Lefkoe Stimulus Process facilitates de-conditioning the stimuli for negative emotions, which has nothing to do with beliefs. In order to get rid of the fear of public speaking, one has to extinguish the conditioned stimuli that have become associated with fear, such as facing criticism, feeling that one is not meeting expectations, that one is being judged, or that one is being rejected. The point of this process is to assist the person to realize that initially the current stimulus never produced the emotion. The current stimulus got conditioned to produce the negative emotion because it just happened to be associated with the real original cause in some way.

Potential effectiveness of the Lefkoe Method

The Lefkoe Method has not previously been subjected to rigorous investigation, although there is reason to believe that it might well be effective in treating a wide range of problems. In 1994 The Lefkoe Institute, in collaboration with Sechrest, conducted a study involving 16 incarcerated youths and adults at two Connecticut institutions. The study indicated fairly strongly that using TLM, specifically the Lefkoe Belief Process, to eliminate such beliefs as 'I'm bad', 'There's something wrong with me', 'I don't matter' and 'What makes me okay is the power that comes from a gun' improved the self-esteem and reduced the hostility and anti-social behavior of the subjects. In part because of the small sample, the study, although reflecting statistically significant effects, was never published; the effect was actually fairly large. The study did, however, provide impetus for Lefkoe to continue use and development of his unique inter-

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vention. He and his associates have by now treated over 2000 people with a wide range of problems, and results as he has seen them have been consistently highly favorable. He has also trained a number of other clinicians in the use of his method, and they, too, have, in aggregate, treated, successfully, a very large number of persons. The experiences of these clinicians constitute a strong basis for more systematic testing of the effectiveness of the Lefkoe approach.

An increasing number of case studies and anecdotal reports provide evidence that TLM has been effective in resolving a wide variety of serious psychological issues, including anxiety, drug and alcohol addition, ADD, bulimia, phobias, the inability to leave abusive relationships, anger, hostility and guilt. It also is successful with everyday issues such as worrying about what people think of you, workaholism, the feeling that nothing one does is ever good enough, procrastination and the inability to express feelings. Whether the anecdotal reports of the effectiveness of TLM with the above-mentioned psychological issues can be replicated in controlled scientific studies remains to be seen.

The significant results obtained in the 1994 study, coupled with the plentiful observational evidence supporting the proposition that TLM might well be both efficient and effective in treating a range of at least mild to moderately severe disorders, prompted us to conduct the present study. In searching about for a test bed for TLM, we hit upon the idea of trying it out with fear of public speaking. This problem is, apparently, not uncommon, it is often at least moderately severe, and many people who experience it are highly motivated to get rid of it. Moreover, Toastmasters clubs and similar groups provide a good entry to the recruitment of persons interested in treatment.

METHODS

This study is the second in what we expect to be a number of studies designed to determine the reliability of the extensive anecdotal evidence.

Participants

Forty volunteers were recruited primarily through Toastmaster groups located near a large metropolitan Western city and were assigned randomly to either the immediate or wait-list comparison condition. Three persons dropped out of the immediate treatment group and one from the wait-list group before beginning treatment or after one session, so that the final sample size was 36. To be eligible for the study, participants had to report at least a moderate fear of public speaking, defined by a self-rating of 5 or greater on a 10-point Likert scale ranging from 1 (*not at all fearful*) to 10 (*extremely fearful*). In addition, participants had to acknowledge that their fear related only to circumstances of speaking in public and not to other broader areas of their life, have access to a telephone, be willing to give informed consent to participate in the study, and be fluent in English. Women comprised 53% of the sample. The mean age was 42.6 (sd = 11.8). On average, participants had 9.6 years (sd = 8.9) of experience with speaking in public.

Experimental Design

Eligible participants were randomly assigned to TLM or a yoked wait-list control group (WL); i.e., subjects were paired at time of assignment. Figure 1 illustrates the study design and timing of questionnaire administration.

A wait-list control design was chosen because the primary endpoint of this study was to determine the reduction in fear associated with speaking in public. This endpoint entailed waiting until after TLM subjects completed treatment and had an opportunity to speak in public. Immediately following their public speaking experience, TLM subjects completed posttest questionnaires and notified the facilitator within 1–2 days so their yoked WL subject could be instructed to complete posttest measures. WL subjects received treatment after the waiting period and completed a second set of the same posttest questionnaires immediately following their first public speaking experi-

Group	Timeline of activities						
TLM	Pretest	Treatment	1st public speaking	Posttest	—	—	—
WL	Pretest	—	—	Posttest	Treatment	1st public speaking	Posttest

Figure 1. Study design and timeline of activities

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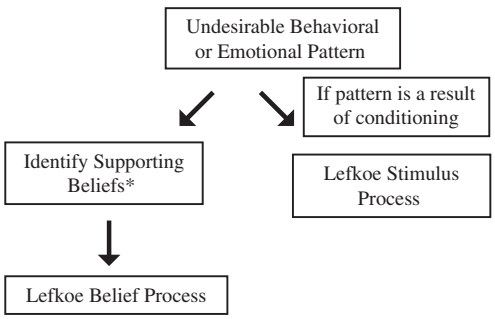

*Belief: The meaning given to a pattern of meaningless events, which then becomes a description of reality one thinks is 'the' truth.

Figure 2. When the LBP and LBP are used

ence. Both TLM and WL subjects attended their Toastmaster sessions during the study and both groups had the opportunity to speak there during the course of the study.

Procedure

Subjects were recruited primarily through announcements made at public speaking clubs or via emails sent to club members. After the study coordinator received a signed consent form and completed baseline measures, subjects were randomly assigned to either the TLM or WL group. Subjects in the TLM group then scheduled a series of phone calls to receive as many individual treatment sessions as would be necessary to eliminate the fear. The range was from two to five sessions, with a mean of 3.3. About half of the 2000 clients who have been treated with TLM receive help over the telephone, and the reported results are always as effective as the in-person sessions (M. Lefkoe, personal communication, 25 March 2004). The facilitator for all subjects in the study was Morty Lefkoe, who has over 20 years of experience in using TLM to assist clients to get rid of a wide variety of emotional and behavioral conditions, including the fear of speaking in public. The treatment consists of one-hour sessions and is delivered according to structured treatment protocols developed by Mr. Lefkoe.

TLM consists of a number of processes, two of which were used in this study: the Lefkoe Belief Process, which is used to eliminate beliefs, and the Lefkoe Stimulus Process, which is used to decondition stimuli that automatically cause specific emotions.

Description of the Lefkoe Belief Process

The LBP begins with the client describing an undesirable or dysfunctional pattern of behavior or feelings that she has been trying unsuccessfully to change. Feeling patterns could include fear, hostility, shyness, anxiety, depression or worrying about what people think of that. Behavioral patterns could include phobias, relationships that never seem to work, violence, procrastination, unwillingness to confront people, an inability to express feelings, sexual dysfunction or anti-social behavior.

Once the client has identified her undesirable pattern, she is asked what she believes that could logically account for that pattern. This step is not the same as asking the client 'why' she acts as she does. Most people either will say they have no idea why they do what they do, or they will come up with a multitude of reasons. A client's 'story', interpretations, and analysis are not at all relevant in the LBP. This step is designed to elicit one or more beliefs (that she probably was not conscious of before the LBP began) that logically would manifest as her undesirable pattern.

A client whose pattern is a fear of public speaking, with a host of physical symptoms when she even thinks about having to give a presentation in front of a group, probably has the following beliefs: mistakes and failure are bad; if I make a mistake I'll be rejected; people aren't interested in what I have to say; what I have to say isn't important; I'm not capable; I'm not competent; I'm not good enough; I'm not important; what makes me good enough and important is having people think well of me; change is difficult; public speaking is inherently scary. In other words, the theory is that the beliefs (and sometimes additional conditioning) cause the pattern.

Once a belief is identified, the client is asked to say the words of the belief out loud to confirm that she actually does hold this belief. If the client has the belief she will notice negative feelings associated with the statement or a sense that the words themselves are true.

Then, the client is asked to look for the earliest circumstances or events that led her to form the belief. Fundamental beliefs about life and about oneself—for example, self-esteem-type beliefs—are usually formed before the age of six (Briggs, 1970). For the most part they are based on interactions with one's parents and other primary caretakers, if any. Beliefs in other areas of life, such as work and society, are formed at the time those areas of life are encountered.

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Although the client can usually identify the relevant early events in five or ten minutes, at times she spends as much as half an hour recalling various events from her childhood. At some point she identifies the *pattern of events* that led her to form the belief in question. Lefkoe's experience with over 2000 clients indicates that beliefs rarely are formed based on only one or two events. Usually a great many similar events are required, unless a really traumatic event occurred.

Using the belief, 'I'm not good enough', as an example, the source might be a childhood in which the client's father was always telling her what to do and what not to do. Nothing she ever did was good enough for him. She never received any praise and was criticized a lot.

The next step is to have the client realize that the current belief was, in fact, a reasonable interpretation of her childhood circumstances and that most children probably would have reached a similar conclusion, given their experience and knowledge at that time in their life. One's beliefs are almost always a reasonable explanation for the events one observes at the time one observes them. Thus the client is never told that her beliefs are irrational or wrong.

This is one of the differences between LBP and CT, where a client is told that her beliefs are irrational and wrong, and shown why.

The client then is asked to make up some *additional* interpretations of, or meanings for, the same earlier circumstances, which she had not thought of at the time. In other words, the client as a child observed her father doing and saying various things over a long period of time. The meaning she gave to the events was *I'm not good enough*. What the client is asked to do is make up additional meanings or interpretations of her father's behavior.

(In CT clients are often asked to create or are shown other ways to interpret events in the present that they currently feel bad about. This is taught as a skill that can be used to get rid of upsets after they happen and to calm fears and anxieties before stressful events. In the LBP this technique is used as part of a process to eliminate a belief, so that the upsets and the anxieties do not occur after the client leaves the therapist's office.)

To continue the illustration we've been using, other reasonable interpretations of her father's behavior and comments could include the following.

- My father thought I was not good enough, but he was wrong.
- I was not good enough as a child, but I might be when I grow up.
- I was not good enough by my father's standards, but I might be by the standards of others.
- My father is a very critical person and would act that way with everyone, whether they were good enough or not.
- My father's behavior with me had nothing to do with whether I was good enough or not; it was a function of my father's beliefs from his childhood.
- My father's behavior with me had nothing to do with whether I was good enough or not; it was a function of his parenting style.

Each of these statements is as reasonable a meaning for her father's behavior as the one she came up with as a child. The point here is not to convince the client that her belief is unreasonable or that any of the other interpretations are more accurate; it is for her to realize that there are many *different* meanings, each one of which is logically consistent with the events she experienced.

Further, notice that not all of these interpretations are 'positive'. They are not designed to make the client feel better. Their only purpose is to help the client realize that her interpretations are 'a' truth, one of many possible interpretations, and not 'the' truth, the only interpretation. This is another difference between the LBP and CBT.

Next the client is asked if, when she formed the belief as a child, it seemed as if she could see in the world that *I'm not good enough*. Because it feels as if we 'discovered' or 'viewed' our beliefs in the world, the answer is always, yes. It seemed to the client that every time her father criticized her or failed to praise something she was proud of, she could 'see' that she was not good enough. Clients usually are so certain that their belief was out in the world to be seen that they frequently say, 'If you were there in my house, you would have seen it too'. Lefkoe has verified with thousands of clients that when one looks back on the events that led to the formation of a belief, the meaning one has given the events seem to be inherent in the events; i.e., it seems as if one can 'see' the meaning in the events.

The client is then asked 'Is it clear, right now, that you never *really* saw the belief in the world?'.

In other words, you want the client to realize that she never did see that *I'm not good enough*. All she really saw was her father's statements and behaviors. *I'm not good enough* was only one interpretation of the events she actually did see.

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After the client realizes that she never really did see her belief in the world, she is asked 'If you didn't see *I'm not good enough* in the world, where has it been all these years?'. The answer is always 'In my mind'.

The client then realizes that the events of her childhood, as painful as they might have been at the time, had no inherent meaning. The events had many possible meanings, but no 'real' meaning before the client assigned the events a meaning.

When a client recognizes that something she has held as a belief (*the* truth) is, in fact, only one of several alternative meanings of what actually occurred (*a* truth), and when she realizes that she never saw the belief in the world, it ceases to exist as a belief. It literally disappears. A belief is a statement about reality that we think is *the* truth. When it is transformed into *a* truth, it is no longer a belief and no longer manifests behavioral or emotional patterns in a client's life.

The LBP makes the following assumptions: An individual gives one possible meaning to a set of meaningless events, after which one seems to 'see' the meaning (i.e. a belief) when observing the events. It usually is difficult to eliminate a belief because the individual thinks she has 'seen' it in the world, which is the primary way people get their information about the world. 'Seeing is believing.' In other words, if you can point to it, it is true. It is very difficult to use logic or any other technique to 'talk one' out of a belief if one thinks one has 'seen' it in the world. On the other hand, if an individual is able to revisit the events and realize that she imposed one arbitrary meaning on a set of meaningless events, that the meaning has only existed in her mind, that had she come up with a different meaning at the time she never would have had the current belief—the belief will be eliminated.

The difference between TLM and Insight Therapies should be clear from this description of TLM. Insight Therapies assume that a person's behavior, thoughts and emotions become disordered as a result of the individual's lack of understanding as to what motivates him or her. The LBP postulates that merely understanding that beliefs cause a pattern, or even identifying the specific beliefs that cause a given pattern, will not affect the pattern. The client needs to eliminate all of the beliefs that cause the pattern.

Moreover, mere understanding of the source of a belief is not sufficient to eliminate it. The client also must recognize that she never saw it in the world and that the events that led to the formation of the belief have no inherent meaning.

Finally, with the LBP it is not necessary to see the connection between the undesirable behavioral or emotional pattern one wishes to change and the beliefs that cause it. In other words, insight into the cause of the pattern is not necessary as long as the appropriate beliefs are eliminated.

Description of the Lefkoe Stimulus Process

Very often people experience negative feelings in their lives on a recurring basis, such as fear, anger, sadness, guilt and anxiety. People experience these feelings every time specific events or circumstances occur, such as fear whenever they make a mistake or someone rejects them, or anger whenever they are asked to do something. In many cases the events that stimulate the feeling in some people do not produce the same feeling in others, and vice versa. Why does an event that is not inherently fearful produce fear in some people and not in others?

What appears to have happened is that an event was conditioned in the past to automatically produce emotions in the present.

Consider a client who experiences fear whenever he is judged or evaluated. This is not inherently fearful. When did he first experience fear associated with being judged or evaluated? Assume the original source of the fear was a father who was never satisfied with what the client did as a child and who showed his displeasure by yelling and threatening. No matter what the child did, the father was not satisfied.

When the client reviews the cause of the fear, he discovers that what really caused the fear was the *meaning* he unconsciously attributed to how his father judged and evaluated him, namely, with yelling and punishing. *The person he depended on for his very survival seemed to be withdrawing his love. No love, no care; no care, no survival*. *That* is what caused the fear. The fear was never caused merely by being judged and evaluated.

The client realizes that had he had been judged and evaluated by his father in a loving, understanding and supportive way there would have been no fear. It was *the way his father acted and the meaning he gave his father's behavior* that caused the fear; namely, the yelling and punishment meant his father was withdrawing his love, which meant abandonment to the child.

The point of the Lefkoe Stimulus Process is to assist the client to realize that initially the current stimulus never produced the emotion. It was only

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produced by the meaning he gave to the original cause; the current stimuli just happened to be associated with the original cause in time.

The Lefkoe Stimulus Process works by helping clients to realize that initially 'being judged or evaluated' never produced fear. The original cause of the fear was the meaning the client attributed to the way he was asked to do something (the anger that accompanied the request), by someone whose survival he depended on (his father). He associated 'being asked to do something' with a loss of love, which ultimately he experienced as 'a threat to his survival'. When the association is broken, when the client realizes that he made this arbitrary association, the events that got associated (being judged or evaluated) no longer cause fear.

Joseph LeDoux (1996), a professor at the Center for Neural Science at New York University, points out 'Extinction [of a conditioned stimulus] appears to involve the cortical [our thinking brain] regulation over the amygdala [the emotional brain] . . .'. This is precisely what the Lefkoe Stimulus Process does.

Notice the parallel between how the Lefkoe Stimulus Process works and how the Lefkoe Belief Process works: When a client makes a distinction between the events that were the source of a belief and the meaning he attributes to those events, the belief is eradicated. When he makes a distinction between the actual cause of an emotion and its associated elements, the emotion will no longer be produced by those elements.

Outcome Measures

Questionnaires were emailed to research subjects. All data were collected by email or fax. Because the major 'problem' being reported by the subjects was the experience of anxiety, that construct was the focus of our attempts to determine the effectiveness of the treatment. Other aspects of the 'problem' include uncomfortable and unpleasant physical sensation, which we also measured. We also included one measure from an established research tradition as a way of anchoring our findings to show that they are congruent with those of other investigators.

Self-rated Performance

Subjects rated their last public speaking experience with five single-item measures including how *fearful*, *anxious*, *satisfied*, *confident* and *relaxed* they felt. Items were scored on a 10-point scale from ranging from1 (*not at all*) to 10 (*extremely*).

Subjective Units of Bothersome Sensations Scale

The SUBSS consists of 12 somatic and cognitive sensations commonly reported as intrusive while speaking in public. Items were rated on a four-point scale ranging from 0 (*not at all bothersome*) to 3 (*severely bothersome*). Subjects were instructed to refer to their last public speaking experience when completing the items. Ratings are summed to generate a total score with a potential range from 0 to 36. Cronbach's alpha for the pretest on this study sample was 0.67.

Confidence as a Speaker

Confidence as a speaker was measured using the Personal Report of Confidence as a Speaker (PRCS; Paul, 1966). The PRCS is a 30-item self-report measure that assesses affective and behavioral reactions to public speaking situations. The items are answered in true–false format; half are keyed 'true' and half are keyed 'false' to control for acquiescent responding. Respondents were instructed to consider each item as it related to their 'most recent public speaking experience'. Scores have a possible range from a low of 0 to a high of 30: the higher the score, the greater the degree of anxiety. Cronbach's alpha was 0.80 for the pretest on the study sample.

Data Analysis

To assess differences for between- and within-group treatment effects, we used a series of one-way analysis of variance tests for each of the outcome measures. The primary outcome measure was the rating of fear associated with the subject's last public speaking experience. Secondary outcome measures included ratings of how satisfied, relaxed, anxious, and confident the subject felt during his or her last public speaking experience, level of confidence as a speaker measured by the PRCS, and bothersome sensations measured by the SUBSS.

Three TLM and one WL subject terminated the study after the first session. Obviously, the number of cases was very small, but attrition from the study did not appear to be associated with any descriptive variables or pretest data. Reasons given for terminating were insufficient time and disappointment at not being given tips about managing anxiety.

RESULTS

Means and standard deviations for all measures at each assessment period are presented in Table 1.

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Table 1. Means and standard deviations for pretest and posttest measures

Measure	TLM group (n = 17)		WL group (n = 19)		
	Pretest *M* (sd)	Posttest *M* (sd)	Pretest *M* (sd)	Posttest *M* (sd)	Posttest[b] *M* (sd)
Fear	6.65 (1.32)	1.38 (0.50)	6.53 (1.71)	6.95 (1.61)	1.53 (0.51)
Anxiety	7.24 (1.75)	1.69 (0.48)	6.89 (1.63)	7.32 (0.67)	1.89 (0.87)
Satisfaction	4.81 (2.31)	8.63 (1.09)	4.42 (1.98)	4.11 (2.23)	7.89 (2.16)
Confidence	4.18 (1.51)	8.81 (0.75)	4.26 (1.76)	4.37 (1.86)	8.16 (1.89)
Relaxed	3.65 (1.80)	8.88 (0.81)	3.42 (1.54)	3.74 (1.63)	8.05 (2.27)
PRCS	19.88 (4.59)	4.50 (3.10)	18.79 (5.09)	20.11 (4.16)	5.32 (4.78)
SUBSS	17.18 (4.54)	2.65 (1.66)	16.68 (5.95)	15.16 (6.82)	2.11 (2.47)

TLM = The Lefkoe Method group; WL = wait-list control group; Posttest[b] = WL scores after receiving treatment; PRCS = personal report of confidence as a speaker; SUBSS = subjective units of bothersome sensations scale.

Because of the somewhat exploratory nature of this study, we report data separately for each measure, partly to determine the consistency of findings.

The data reported in Table 1 are remarkably consistent across measures, including the PRCS, a measure well established in the literature. Particularly noteworthy is the fact that subjects in the WL group did not change at all on any measure until treatment, after which their scores were closely equivalent to those of persons in the initial treatment group. Thus, the change cannot be attributed to effects of retesting. First, there were no significant differences between groups on any measure at pretest. Second, scores in the TLM group at posttest were dramatically different from WL posttest scores. Third, after they received treatment, subjects in the WL group had scores that were not different from those at posttest for the TLM group. Figure 3 is a graphic display of 'average' results for all outcome measures. The figure shows quite well the change occurring in each group when treatment takes place and the apparent magnitude of the treatment effect, which seems quite large. Just to illustrate, across the 12 items in the SUBBS, at pretest subjects would have been reporting patterns of response something like

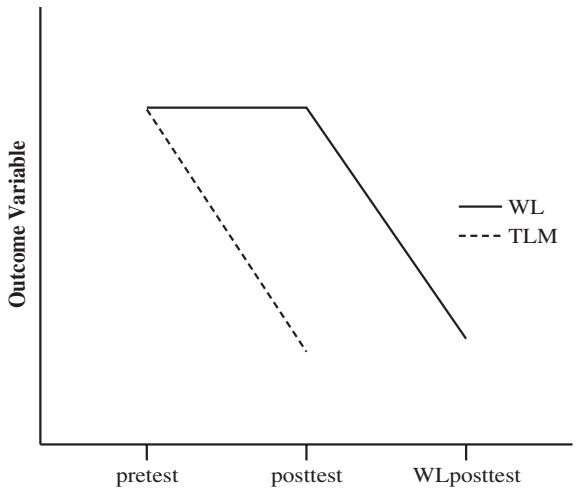

Figure 3. Mean ratings before (pretest) and after (posttest) treatment

ratings of 1 on six items and ratings of 2 on six more

or

ratings of 2 on six items and ratings of 3 on two more

or

ratings of 2 on eight items.

After treatment, the patterns would have been more like

ratings of 1 on three items

or

rating of 2 on one item and rating of 1 on another item

or

rating of 3 on one item.

Between-Group Effects at Posttest

Table 2 presents between-group effects. Results were large differences on all outcome variables when comparing TLM and WL posttest scores. By contrast, comparisons of TLM posttest scores with scores for the WL group after having received treatment (Posttest[b]) were very small and associated with uniformly small and non-significant *F*-values.

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Table 2. Between-group effects (*F*-values) for posttest measures[1]

Measure	TLM vs. WL Posttest		TLM vs. WL Posttest[b]	
	F	*p*	*F*	*p*
Fear	175.55	0.001	0.77	0.39
Anxiety	786.62	0.001	0.71	0.40
Satisfaction	54.45	0.001	1.50	0.23
Confidence	79.89	0.001	1.69	0.56
Relaxed	131.75	0.001	1.89	0.18
PRCS	153.14	0.001	0.34	0.56
SUBSS	54.23	0.001	0.58	0.45

TLM = The Lefkoe Method group; WL = wait-list control group; Posttest[b] = WL scores after receiving treatment; PRCS = personal report of confidence as a speaker; SUBSS = subjective units of bothersome sensations scale.

[1] We know that results could have been summarized by a single score and a single *F* test, but we present the results in this way, with a series of univariate tests, to show the remarkable consistency of the outcomes.

Table 3. Within-group effects (*F*-values) for pretest to posttreatment in TLM and WL groups

Measure	TLM Pretest vs. posttest *F**	WL Pretest vs. posttest *F*	WL Pretest vs. posttest[b] *F**
Fear	224.51	0.61	34.19
Anxiety	149.81	1.08	138.85
Satisfaction	35.53	0.21	26.72
Confidence	122.29	0.03	43.16
Relaxed	113.31	0.38	54.11
PRCS	125.49	0.76	70.61
SUBSS	153.38	0.54	97.19

* $p < 0.001$; otherwise, *F*-values are non-significant.
Posttest[b] = WL scores after receiving treatment.

On average, subjects in both groups received three sessions ($F(1, 34) = 0.25$, $p > 0.62$). Only three subjects in the WL group required a fifth session.

Within-Group Effects from Pretest to Posttest

Analysis of within-group changes from pretest to the first posttest showed significant treatment effects for all outcome measures in the TLM group and no such changes in the WL group (see Table 3). Across all outcome measures, after WL subjects received treatment, their scores were negligibly different from those in the TLM group.

To assess the magnitude of the treatment effect, we calculated Cohen's *d* [$(M_{post} - M_{pre}/SD_{pre})$] (1988). Because the pretest and posttreatment values in the TLM and WL groups were not significantly different from one another, we pooled their data. All effect size estimates were substantial (fear $d = 3.36$, PRCS $d = 2.97$, SUBSS $d = 2.76$).

Subjects were asked to rate how helpful the sessions were for them in reducing or eliminating their fear of speaking in public on a 10-point scale on which 1 was '*not at all helpful*' and 10 was '*extremely helpful*'. Ninety-four percent of the sample rated the treatment as 7 or higher.

DISCUSSION

The large, positive changes on all outcome measures subsequent to treatment give strong support to the claim of efficacy of the TLM for reducing fear associated with speaking in public. The fact that change was of the same magnitude even for the wait-listed subjects adds to the robustness of the evidence of TLM's efficacy. The TLM resulted in substantial decreases or complete eliminations of fear, accompanied by positive changes in confidence and reduced negative sensations felt during speaking in public, in both groups. Overall, the TLM appears to have potential as an effective, quick, and convenient procedure to eliminate the fear of speaking in public.

It is true that the measures we used all involve self-report, but, as noted earlier, the complaint with which people began was self-report. Moreover, we do not think that measures such as observations would necessarily be informative, and they would have been difficult to arrange in a way that would produce reliable findings. Some people with high levels of anxiety are able to cover it up very well, and other people with no anxiety at all can appear flustered if they have not prepared well. Thus, for a study that is attempting to determine whether an intervention is effective in eliminating a subject's experience of anxiety, asking the subject to rate his level of fear (and his related physical symptoms) both before and after the intervention is the best option to reliably determine whether or not the intervention is successful.

Because the treatment group was tested after giving a speech and the control group was not, it might be argued that the active treatment ingredient is the exposure to public speaking, rather than TLM, given the substantial evidence of the effectiveness of exposure methods for social anxiety. There are two answers to this argument. First, sub-

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jects from both groups had spoken many times prior to the study without any significant reduction in the fear. In fact, Toastmaster membership requires regular speaking. Second, to the extent desensitization works, it requires repeated exposure, not one. It would make little sense to claim that subjects who spoke regularly at Toastmaster meetings who reported a fear level with a mean of almost 7 reduced the fear to a mean of 1.5 merely by giving one additional talk.

We want to argue at this point that TLM is a profoundly *psychological* method, a direct application of psychological constructs and principles to the effecting of behavioral change (Sechrest & Smith, 1994). The method is centered on the concept of *belief* and a paraphrasing of the idea of *isomorphism of experience and action* (Campbell, 1963). That is, in general, and, we think, to a very great extent, people will act on the basis of what they believe to be true as a result of their prior experiences and mental processing of them. If people believe that another person is liable to harm them, they will want to stay away from that person. If people regard some situation as fearsome and they believe themselves to be incapable of mastering their fear, they will avoid that situation. TLM is a way of helping people recognize and eliminate beliefs that, however warranted they may once have been, are no longer relevant to the problems that face them today.

TLM has a good bit in common with CBT, RET and other generally cognitive methods of therapeutic intervention, but it is not simply a reformulation of any of them. In its emphasis on eliminating beliefs, rather than learning to cope with them, it is distinctive. It is also distinctive in its claim that the problems resulting from those beliefs can be eliminated entirely, not just reduced by some degree. The appropriate outcome test for TLM is a category change (from having a problem to not having any problem) rather than a reduction in the mean value of the problem. This is a bold claim, and it remains to be seen whether it can be upheld for a wide range of problems. The present results are certainly suggestive of the possibility that TLM might be able to do just what it says.

Public speaking anxiety was chosen for the sake of convenience in completing an initial test of TLM, not out of any particular interest in providing a treatment for public speaking problems *per se*. We believe that the results of this study should be interpreted as demonstrating that TLM may be a useful intervention for dealing with mental and behavioral disorders that are to some extent debilitating.

Our plans for the immediate future are to develop a strategy by means of which it will be possible to recruit a number of therapists trained in TLM who will agree to participate in randomized trials to assess the usefulness of TLM in treating a range of problems common in clinical settings. The aim is to make TLM generally available to clinicians as an alternative tool for discharging their professional responsibilities.

We do need, obviously, to determine how long the effects of TLM are sustained. Six-month follow-up questionnaires available currently for 23 of the 37 subjects indicate that the TLM approach has a long-sustained effect for our primary variable of interest, the experience of fear while speaking in public. Ratings based on 23 returned questionnaires range from 1 to 4 with a mean of 1.9 (sd = 1.0), values that are not different from those obtained at posttest.

The impressions of clinicians who have used TLM are that the effects are quite durable.

One additional point that is worth attention is that the intervention reported on here was conducted entirely by telephone; the facilitator, Lefkoe, never saw any of the participants. Although participants were all residents of west coast communities, mostly in the Bay area, that was solely because they were recruited from public speaking clubs identified by Lefkoe. In principle, the intervention could have been delivered anywhere in the English-speaking world. It is also important that the intervention was actually quite brief. These characteristics of TLM, for the kinds of problems exemplified by fear of public speaking, indicate that the intervention should be highly cost effective and that it could be made widely available.

A potential limitation of this study was the dependency on self-report data. However, we find the consistent response patterns of subjects in both groups to be compelling enough to rule out demand characteristics often associated with self-report data. At the very least, we think these results provide a strong basis for recommending further rigorous testing of TLM.

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