

# **Can Emotional Freedom Techniques (EFT) be effective in the treatment of emotional conditions? Results of a Service Evaluation in Sandwell.**

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## **Introduction**

EFT (Emotional Freedom Technique) which is also known as “Tapping Therapy” and “Acupuncture Without Needles”, is a new and emerging complementary therapy. It is a gentle therapy that can be used for a variety of issues. Subjects gently tap with their fingertips on acupressure points (mainly on the head and hands) and relate this to the voicing of specific statements (Callahan & Trubo 2001; Craig 2011).

Research to date has indicated that EFT (Craig 2011), and its predecessor Thought Field Therapy (TFT; Callaghan & Trubo 2001) has been used in treating a wide range of conditions and phobias such as needle phobia (Darby 2001), claustrophobia (Lambrou *et al* 2003), fear of small animals and insects and other phobias (Wells, 2003, Salas 2010), fibromyalgia (Brattberg 2008), weight loss maintenance (Elder *et al* 2007), food cravings (Stapleton *et al* 2011), social phobia and agoraphobia (Irgens *et al* 2007). EFT has also been used to treat teacher burnout (Reynolds & Walden 2010), anxiety (Andrade & Feinstein 2004), presentation anxiety (Boath *et al* 2012A) and post traumatic stress disorder (Karatzias *et al* 2011). EFT is currently the subject of several ongoing trials and studies, including one addressing the effects of EFT on Stress Hormones (Cortisol) and the impact of EFT on depression (Soul Medicine Institute 2011). A recent editorial also suggests that EFT may have the potential to lower healthcare costs by a significant amount (Church 2010).

A review of the preliminary evidence for EFT and TFT has been carried out (Feinstein 2008). This review included a range of evidence from anecdotal reports to randomized clinical trials and highlights the preliminary nature of the current evidence base for EFT and TFT, as well as the limitations of the research to date. A more recent review (Feinstein 2012) critically evaluated 18 randomised controlled trials and concluded that therapies involving the tapping of acupuncture points demonstrated strong effect sizes and positive statistical results in relatively few treatment sessions. Another recent review (Boath *et al* 2012B) reviewed a number of randomised controlled trials of EFT for a variety of conditions; it concluded that EFT may be an efficient and effective intervention for a range of psychological disorders, but highlighted methodological limitations of the RCTs, and recommended further good quality research on EFT.

Sandwell, an urban district in the West Midlands introduced the EFT service in November 2010, though EFT had previously been used within the PCT. The service initially comprised two clinical sessions (each approximately half a day) per week, and this was increased to three sessions in April 2011. It was launched as part of Sandwell's Confidence and Wellbeing Team Service (CWBT, Sandwell, 2012). The Team offers a range of services, aiming to create opportunities for people to maintain and improve their own wellbeing and provide community and primary health care mental health services that are flexible and meet the emotional needs of those living and working in Sandwell. To the authors' knowledge, this was the first dedicated EFT service established within the NHS. This service evaluation was therefore undertaken to establish the effectiveness of the EFT service.

## **Methodology**

The evaluation of the EFT service was conducted over a 13 month period. All Sandwell GPs and health professionals were given information about EFT and the service; clients were also able to self-refer. All referrals came through a centralised hub. Referrals were accepted for any condition, providing that clients were aged over 18, and not classed as "vulnerable adults".

The therapy was delivered by AS, a qualified and experienced EFT practitioner and researcher. Prior to the service launch, ethical approval for the service evaluation was secured from both Sandwell PCT and Staffordshire University. All clients were invited to give informed consent to their data being used.

At the start and end of their treatment, clients were asked to complete each of the following measurement scales: CORE-10 (the main outcome variable) for psychological distress covering anxiety, depression, trauma, physical problems, functioning and risk to self (CORE IMS, 2012), Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith 1983), Rosenberg Self-Esteem Scale (Rosenberg 1989) and the Warwick-Edinburgh Mental Well-being Scale (WEMWBS, 2012). Sandwell CWBT used the online CORE NET system (CORE IMS 2012), and required CORE-10 and WEMWBS scales to be electronically administered at each appointment to track progress and gather routine data; this data collection was separate from the service evaluation. Clients completing their therapy were also invited for a 3-month follow-up appointment where their progress was checked and all four measurement scales were again administered.

Each client was given a brief introduction to EFT, including a simple rationale for the method. Following this, they were guided through the tapping process by AS. The EFT protocol initially followed the “basic recipe” (Craig 2011), tapping on 12 acupressure points (5 on the head, 2 on the torso and 5 on the hand) while tuning in to the emotional issue. Depending on the issue, a variety of EFT approaches were utilised and these were tailored to each individual client e.g. the movie technique, the choices method and matrix reimprinting, an extension of EFT (Dawson & Allenby 2010). Once learned, EFT is easily self-administered, and clients were given a reminder guide on using EFT, and instructed that they could continue to use EFT on themselves any time they required between sessions.

Initial appointments were for 60-90 minutes duration, with each subsequent appointment lasting for 45-60 minutes.

Data analysis was undertaken in SPSS v19 (IBM 2010). Mean pre, post and follow-up scores for each measurement scale were analysed using paired *t*-tests (or

Wilcoxon Signed-Rank tests for non-normally distributed variables). Further *t*-test and correlation analysis was carried out to test for differences in scores between gender and age. Data for all clients who gave consent and completed their treatment or discontinued before the end of the evaluation period were included in the database and analysed.

## **Results**

A total of 39 clients gave consent, and 31 (79.5%) of these completed their therapy. There was a distinct though non-significant ( $p=0.355$ ) gender difference between males completing treatment (6; 66.6%) and females (25; 83.3%).

A total of 30 (76.9%) clients were female. The mean age of all clients was 45.37 (range 18-76). For females, the mean age was 47.34 (range 18-76) and the mean for males was 39.00 (range 23-63); the mean age difference between genders was non-significant ( $p=0.574$ ). In all, 31 (79.5%) of clients were White British. A further three clients were Indian (7.69%), plus one client (2.56%) each for Black African, Black British, Yemeni, Pakistani and Mixed Race.

The mean number of sessions attended was 5.05 (median 4.0; range 2-17). All but two clients received 9 sessions or less, with one client receiving 12 sessions and another receiving 17 sessions.

The main presenting conditions were anxiety (23; 59.0%), depression (5; 12.8%) and anger (4; 10.3%). Clients generally revealed up to four additional issues. The conditions addressed during therapy are presented in Table 1.

Conditions addressed during therapy	Frequency	Males with condition	Females with condition
Anxiety	29	6 (66.6%)	23 (76.6%)
Depression	18	6 (66.6%)	12 (40%)
Insomnia	13	6 (66.6%)	7 (23.3%)
Self Esteem	9	3 (33.3%)	6 (20%)
Anger	7	3 (33.3%)	4 (13.3%)
PTSD	4	0	4 (13.3%)
Obsessive Compulsive Disorder	3	1 (11.1%)	2 (6.66%)
Panic	3	2 (22.2%)	1 (3.33%)
Phobia	3	0	1 (3.33%)
Sexual Abuse	3	0	3 (10%)
Bereavement / Sadness	2	0	2 (6.66%)
Eating Disorders	2	0	2 (6.66%)

*Table 1. Summary of conditions treated.*

It can be seen that males in this evaluation were more likely to report depression, insomnia, self-esteem, anger, obsessive compulsive disorder and panic. Females were more likely to report anxiety, PTSD, phobia, sexual abuse, bereavement / sadness and eating disorders.

A summary of results are shown below:

Measurement Scale	Mean score Pre-EFT	Mean score Post-EFT	SD (Difference)	P value (* Significant)	N=
CORE-10	20.16	8.71	6.81	<0.001 *	38
WEMWBS	38.27	53.62	10.88	<0.001 *	37
Rosenberg Self-Esteem	14.16	21.81	6.88	<0.001 *	31
HADS Anxiety	13.22	7.30	3.57	<0.001 *	23
HADS Depression	9.26	4.87	5.25	0.001 *	23
HADS Total	22.30	12.13	8.17	<0.001 *	23

*Table 2. Results of inferential analysis pre and post-EFT.*

Measurement Scale	Mean score Pre-EFT	Mean score Follow-up	SD (Difference)	P value (* Significant)	N=
CORE-10	18.71	7.14	6.37	0.003 *	7
WEMWBS	40.00	53.29	11.27	0.021 *	7
Rosenberg Self-Esteem	14.29	22.43	6.45	0.016 *	7
HADS Anxiety	14.25	5.50	4.03	0.068	4
HADS Depression	8.50	2.75	2.50	0.019 *	4
HADS Total	22.75	8.25	5.32	0.068	4

*Table 3. Results of inferential analysis pre-EFT and 3 month follow-up.*

Differences in before and after scores were all statistically significant and where interpretable, also clinically significant. Differences between pre and 3 month follow-up scores were also clinically significant, though HADS Anxiety and total HADS did not reach statistical significance; the very small sample size may account for this.

Most of the measurement scales used have acknowledged thresholds for “caseness”. CORE-10 has a national 'clinical cut-off' score of 10; mean CORE-10 scores were well *over* 10 (caseness) at start and *under* 10 (normal) at end. HADS scores (for anxiety and depression domains individually) of 0-7 are considered normal, 8-10 indicates cause for concern, while 11-12 represent probable clinical cases requiring assessment. Both HADS anxiety and depression domains were *over* 8 at start and *under* 8 at end. Mean Rosenberg Self-Esteem scores were less than 15 at the start (indicative of low self-esteem), but were in the normal range (15-25) at the end. WEMWBS scores (where higher scores represent higher mental wellbeing) also increased significantly.

There were no statistically significant differences in scores between gender or age. The limited sample size prevented further meaningful stratified inferential analysis, however.

Figure 1 shows CORE-10 scores at the start of therapy, plotted against scores at the end. Each dot represents a client seen by the service who gave consent. CORE-10

scores at the start (left-hand side) are plotted against those at the end of treatment (bottom). Clients shown on the left-hand side of the diagonal line improved, while those on the right hand side of the line deteriorated. It can be seen that all but one clients improved between the two time points. The single client (signified by a red dot) who got worse had OCD; this client found it difficult to engage with EFT. Although EFT did not appear to be successful for this particular client, a further client with OCD achieved a clinically significant improvement.

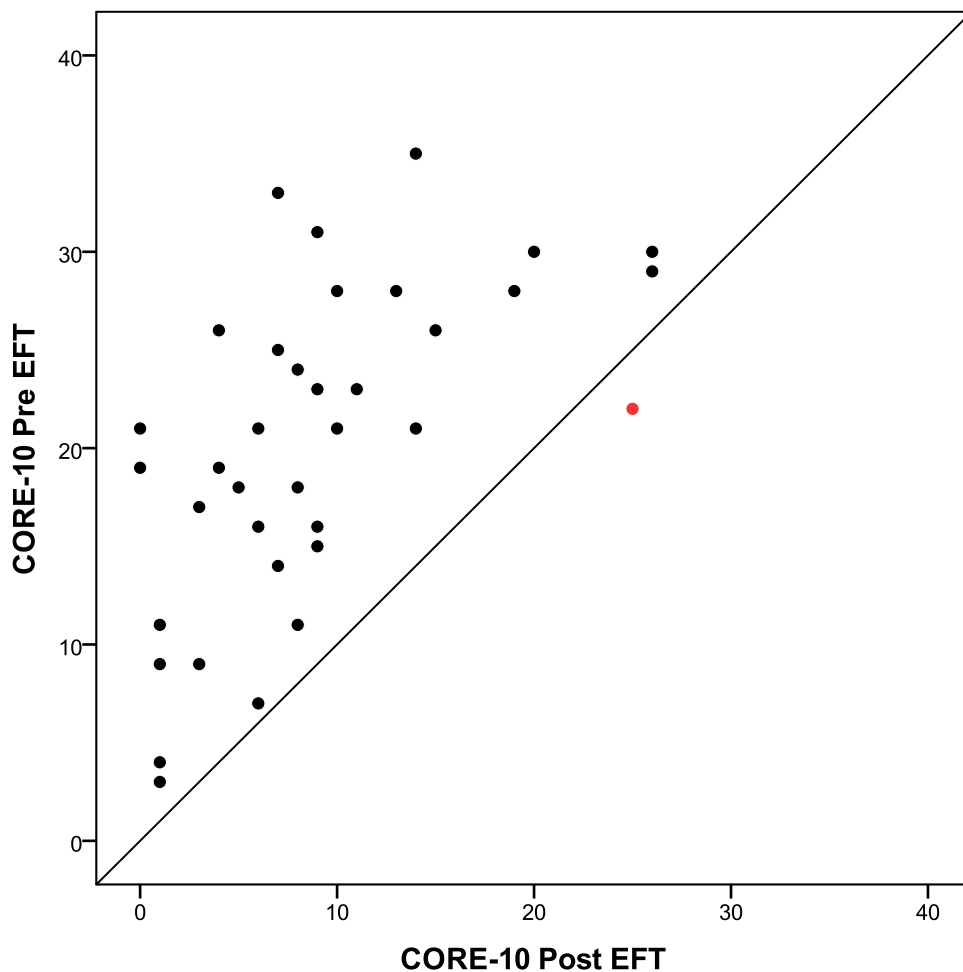


Figure 1. Scatter Plot for CORE-10 scores at start and end of therapy.

Out of 125 referrals during the service evaluation period, 25 did not attend their first appointment (20%). A further 17 did not wish to continue and 29 lost contact (37%), and a further 15 (12%) were in progress.

## **Discussion**

There is much speculation about mechanisms to explain the effectiveness of EFT and a dismantling study has been suggested (Karatzias *et al* 2011). Despite the lack of agreement on its mechanisms however, a recent systematic review has revealed that EFT is effective in treating a variety of conditions including Post Traumatic Stress Disorder (PTSD), fibromyalgia, phobias and anxiety (Boath *et al* 2012B) and a further review has reported strong and rapid clinical outcomes for a range of conditions (Feinstein 2012). Indeed, EFT has been shown to be superior to diaphragmatic breathing (DB), Progressive Muscular Relaxation (PMR), an inspirational lecture and a Support Group and was shown to be as effective as Eye Movement, Desensitization and Reprocessing (EMDR) in treating PTSD (Karatzias *et al* 2011).

A general risk about having clients talk about trauma is that it will lead to retraumatization rather than desensitization (van der Kolk *et al* 1996). This safety issue is minimized with EFT, as clinicians note a general absence of abreactions and client distress when using EFT (Mollon 2008). A survey of psychotherapists who use both EFT and other methods such as eye movement desensitisation & reprocessing therapy (EMDR) and Cognitive Behavioural Therapy (CBT) found that clinicians preferred the use of EFT in cases where clients were asked to recall traumatic memories, in order to resolve these core clinical dilemmas (Schulz 2009).

The NICE guidelines for PTSD advise psychological treatments such as CBT or EMDR (NICE 2005). However, a recent publication of a randomised controlled trial (RCT) of EFT versus EMDR in treating PTSD demonstrated that EFT was as effective as EMDR (Karatzias *et al* 2011). It is therefore timely to assess whether EFT is an effective intervention for conditions such as childbirth induced PTSD and to explore client's views of EFT.

Problems were experienced in encouraging clients to complete their therapy and attend for follow-up appointments, despite using text appointment reminders and offering telephone sessions and submission of measurement scale forms by post or email. Several clients contacted the service to say they would not be attending



further appointments because they felt that their issues had been resolved, and were unwilling to attend for follow-up. Some of these clients agreed to complete the measurement scales by letter or email, but only two sets of forms were actually received in this way. Some clients failed to complete all of the measurement scales.

In this evaluation, clients were offered 45-60 minute sessions. The optimal duration of an EFT session and the optimal time for follow-up is not clear. For example, Baker & Siegel (2005) assessed the impact of one 45 minute session of EFT and found that the effect was still evident at the 16 month follow-up, whereas Wells *et al* (2003) found enduring results of a 30 minute EFT session at 6-9 months follow-up.

The authors' clinical experience suggests that some people find the idea of EFT absurd, let alone the idea that it may have an impact on their psychology, and other research supports this assertion (Burkeman 2007; Gaudiano & Herbert 2000). In spite of this, most clients continued to attend and to improve.

### **Limitations of the Evaluation**

This study was a service evaluation, so no comparative groups were used. As only quantitative assessments were included, clients' views about their treatment were not explored. This evaluation was, however, intended as a feasibility study which would hopefully lead to a larger RCT.

Experience, training and professional background of practitioners is important, and the EFT was carried out by a highly trained and experienced EFT practitioner. Variability in skills and experience of practitioners would however be expected in other settings.

Further inferential data analysis was hampered by the small number of clients in the evaluation, especially at follow-up. Sample size was restricted by the fact that AS could only offer a limited number of weekly appointments, as well as factors such as reluctance to give consent, drop out and low attendance for follow-up. Few reasons

were given for dropout, though the dropout rate was similar to other studies involving EFT (Karatzias *et al* 2011 (39%); Boath *et al* 2012A (33%). Although the required sample size was not determined prior to the commencement of the evaluation, a post-hoc sample size calculation using the main outcome variable (CORE 10) revealed that 27 subjects would be required in order to reach 80% power – this number was exceeded in practice.

The fact that clients could be referred for EFT (or self-refer) for any condition may have introduced both selection and information biases. The diverse nature of emotional issues reported and address during therapy has diluted the frequencies involved, thus limiting the ability to produce meaningful stratified analysis by condition.

Clients were not asked to keep a diary, making it impossible to assess their use of EFT between sessions. AS delivered the EFT and also collected the evaluation data; clients were aware that he was evaluating the service, and this may have biased their responses. Also, AS's strong allegiance to EFT may have influenced clients' responses.

The limitations of the study design and small sample size therefore precludes the ability to infer its results to the wider population.

### **Conclusions and Recommendations**

Despite the limitations outlined above, the results of this evaluation highlight the successful role of EFT in reducing a wide range of physical and psychological disorders.

Given that it takes a very short time for clients to learn to use EFT and that once learned, EFT can be very effectively self-administered suggests that it may be suitable for wider use. Furthermore, EFT can easily be transferred to other aspects of people's lives, for example work stress and financial pressures, and so could be used to enhance general health and wellbeing. On average, just over 5 sessions

were required (with a median number of 4 sessions), suggesting that EFT may be a very cost-effective treatment.

Larger studies (preferably clinical trials) are required to assess both the clinical effectiveness and cost-effectiveness of EFT. Future studies should include a protocol for minimising dropouts and loss to follow-up, such as a robust system of tracking, reminders and contacting clients to elicit completion of all measurement instruments and other information where required. Evaluations should also consider including qualitative assessments to provide a range of rich data to highlight participants' views and opinions of EFT. Such an RCT is currently being planned by the authors. It is also important to assess the optimal duration of an EFT session, the long term duration of effect and fidelity measures to measure practitioner performance across clients.

EFT therefore shows promise as a useful clinical tool, with possible applications for a number of mental health services and other lifestyle areas. Further research is ongoing, which may provide definitive evidence of its effectiveness.

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