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Emotional Freedom Techniques

Background/Definition

A brief exposure therapy with both a somatic and cognitive elements (Church et. al, 2013), Emotional Freedom Techniques (EFT) is a psychotherapeutic tool used with the goal of relieving a variety of psychological conditions and/or somatic symptoms (Brattberg 2008). EFT treatment can be administered by a therapist and also taught to individuals for later self-administration (Salas et al., 2011).

EFT emerged from Thought Field Therapy, a modality that uses a diagnostic system to identify certain acupressure points to stimulate (in a specific order) and restore a body's energy balance. EFT is distinct partly because it explicitly identifies a specific and un- ordered set of 12 acupressure points as locus areas for stimulation (Church et al., 2012).

Theory

EFT theory is based on the perceived connection between an individual's thoughts, emotions, subtle energies, neurological activity and cellular function. EFT interact with an individual's neurophysiology to help reestablish physical, emotional and psychological balance and stability (Benor et al., 2009).

EFT theory derives from the belief that negative emotions arise through disturbances in the body's meridian system or energy field. The process of tapping on acupuncture points while focusing on a negative emotion ultimately balances the patient's energy field (Brattberg, 2008).

Drawing from the knowledge base of Traditional Chinese Medicine, these acupressure points are located on or near the endpoints of certain meridians. The founder of EFT, Gary Craig, and proponents of EFT highlight the use of these meridians as a principal mechanism for EFT treatment efficacy (Salas et al., 2011).

Procedure

The EFT process removes blocks to healing starting with a statement concerning the negative problem, combined with repetitive self-affirmations and tapping (Benor et al., 2009). Essentially, EFT uses a combination of cognitive and somatic procedures. The former, which comes first, involves a self-assessment of stress level, and a pairing (called the "setup

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statement") of an exposure statement and a self-acceptance statement. The somatic element then follows and involves rounds of "tapping," either by the therapist or subject, of one or two fingertips on twelve different points on the body while repeating the setup statement (Church, 2010).

Review

Research on EFT has focused on a wide variety of health problems such as phobias (Lambrou, Pratt, Chevalier, 2003; Salas, Brooks, Rowe, 2011; Wells, Andrews, et. al. 2003), fibromyalgia (Brattberg, 2008), teacher burnout (Reynolds, 2010), anxiety (Andrade & Feinstein, 2003; Benor et al., 2009; Boath, Stewart, & Carryer, 2012), trauma and stress (Church 2010; Church et al., 2012; Swingle 2004), depression (Church, 2012), and food cravings (Stapleton, Peta, et al., 2011; Stapleton, Sheldon, Porter, 2012).

In their studies focusing on phobias and EFT, both Salas, Brooks, and Rowe (2011) and Wells, Andrews, et. al. (2003) reported that their data suggested EFT efficacy and certainly warrant future research. In the former study a lack of follow-up and short intervention period (10 minutes) were acknowledged as limitations (at least in terms of durability of effects). Both groups of authors note that to better test the efficacy of EFT for phobias it must be tested in comparison to existing treatment techniques. They also note that further studies should attempt to isolate the energy component (i.e. tapping specific meridian points), which could be achieved by tapping non-meridian points as a control condition.

One study of EFT as a treatment for phobias contends that the effectiveness of EFT is not attributable to the tapping of meridians, rather it is those characteristics of EFT which are similar to traditional therapy methods for phobias that produce results (i.e. EFT with breathing techniques) (Waite, Holder, 2003). In this same vein, Pignotti and Thyer (2009) argue that in order to ascertain sound experimental evidence for the healing efficacy of EFT itself future studies must employ placebo tapping points and sequences, or control groups with "sham points," as well as wait-list control groups to better isolate the specific treatment outcomes of EFT as an energy therapy.

Several studies reported severe attrition rates, reducing both sample sizes and generalizability of results. For example, Brattberg's (2008) experimental group had a dropout rate of 40% and the author reports the highly positive results with this limiting factor made clear. Lack of motivation, skepticism of the treatment and "too much to do" were cited as reasons for ending compliance. Brattberg suggests a motivational measure such as "contact with good role models who have positive experiences of using EFT" as a possible way to limit attrition.

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Boath, Stewart, and Carryer (2012) performed a small pilot study testing EFT's effectiveness in ameliorating public speaking anxiety (Presentation Expression Anxiety Syndrome) and reported promising results. As a preliminary study with a small, homogenous sample size, the data do not establish EFT as a definitively effective treatment, but the author's do suggest that the results warrant further study in this area. Other limitations of the study include no control group, an extensive period (nine weeks) between EFT training and the anxiety stimulus (the presentation), a significant drop out rate (33%), no specific instruction to continue tapping after the training, and no compliance assessment (frequency and duration of tapping). The authors note these methodological limitations exist in many of the existing preliminary studies and call for future research with tighter protocols.

In two pilot studies assessing the effectiveness of EFT in reducing the symptoms of trauma (Church, 2010; Church, Piña, et. al., 2012) the authors reported significant effects. Church (2010) tested a population of veterans experiencing symptoms of PTSD. After five days of treatment with EFT, participants were no longer scoring at PTSD levels on standard military tests, and a year-long follow up confirmed the endurance of that progress. These promising results come with a caution from the author that a small sample size and no control group limit generalizability. Future, more extensive and comprehensive research is suggested.

Church, Piña, et. al (2012) tested a population of traumatized teens characterized by "intrusive memories" and "avoidant symptoms." Training in EFT was administered and after one month the intervention group was re-assessed; the data showed that the symptoms no longer presented and scores on the outcome measure had normalized. Again, the sample size was extremely small (eight) but the authors state that the data suggests future research is warranted, specifically to determine "if these effects hold over greater periods of time, how they compare to a placebo or active comparator, and whether client-rated assessments agree with observer-rated instruments." This last factor marks an important condition not found in most of the existing literature and, if used in future studies, would offer a more comprehensive picture of the treatment outcomes.

Church et al. (2012) conducted the first randomized controlled trial of EFT to evaluate a physiological biomarker such as cortisol levels. Another remarkable aspect of the study is its rigorous design which included both active and inactive control groups, and triple- blinding methods that concealed the experimental hypotheses from the not only the subjects and evaluators, but also the therapists. The results are very exciting and set the stage for further research to explore whether EFT affects other physiological systems, including the expression of genes involved in the stress response."

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It is evident that while numerous studies in this review demonstrate the apparent effectiveness of EFT treatment, the limitations of this existing research are wide. Almost all the authors have cautioned that while the data suggests efficacy, because of small sample sizes and a slew of other recurring methodological limitations, it lacks confident generalizability; they suggest additional studies with more comprehensive and experimentally rigorous protocols (Benor et al., 2009; Brattberg, 2008; Church et. al, 2009; Church et. al, 2012; Stapleton et al., 2011; Stapleton, Sheldon, Porter, 2012; Swingle, Pulos, 2004; Wells et. al, 2003).

Boath, Stewart and Carryer (2012) echo these conclusions, highlighting the small sample sizes, poorly randomized trials, failures to assess compliance, high dropout rates and the need for more standardized outcome measures as cautionary markers that point to the preliminary status of the evidence for EFT in the literature. They are currently working on a systematic review of EFT and have identified six randomized controlled trials as of April 2012.

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