Self-administered EFT (Emotional Freedom Techniques) for individuals with Post-Traumatic Stress Disorder (PTSD) taught via the Internet

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Abstract

The aim of this study was to examine if self-administered EFT (Emotional Freedom Techniques) leads to acceptance and improvement in individuals with posttraumatic stress disorder (PTSD). 25 individuals with post-traumatic stress disorder, 19 women and 6 men with a mean age of 40, participated in a four-week EFT treatment program which was administered via the Internet.

Upon completion of the program, statistically significant improvements were observed for the following self-rated variables PTSD, anxiety, depression, self-rated function, and acceptance. Self-administered EFT seems to be a good complement to other treatments and rehabilitation programs. The sample size was small and therefore the surprisingly good results have to be interpreted with caution. However, it would be of interest to further study this simple and easily accessible self-administered treatment method, which can even be taught over the Internet, in a randomized study.

Key words: Emotional Freedom Techniques (EFT), Post-Traumatic Stress Disorder (PTSD), Internet-based interventions.

Introduction

Emotional Freedom Technique (EFT), created by Gary Craig in the middle of 1990's, is a controversial psychotherapeutic tool that introduces the principles of acupuncture into psychotherapy and intends to relieve many psychological conditions, including depression, anxiety, PTSD, stress, addictions and phobias. EFT has also been used for treatment of somatic symptoms such as different pain conditions. A comprehensive algorithm is used for all types of problems and symptoms (Craig, 2010). The method consists of a *tapping part*, used to "rebalance the energy system", a *verbal part* that involves making appropriate affirmations, and an *eye rolling part* with the aim to increase activity in the connection between the two halves of the brain. EFT thus aims at combining physiological effects of meridian treatment (acupressure) with mental focusing on thoughts of the trauma/symptom/problem, and the releasing "eye roll" method that sometimes is used in hypnotic procedures. Thus, the procedure involves important elements from several therapeutic methods currently used, such as 1) acceptance and defining the problem; 2) mobilizing the neuronal networks involved during behavioral activation (keeping the problem in mind during the tapping procedure), and 3) interventions lowering physiological activation (tapping and "eye roll").

Acceptance therapies

The concept of acceptance is receiving increased attention as an important ingredient in cognitive behavioral therapy. Acceptance can very well be of importance in the suffering that is often associated with posttraumatic stress disorder (PTSD). This approach differs from established treatments in that it does not principally focus on reducing symptoms, but on reducing the distressing and disabling influences of the symptoms. Increasing data support the view that individuals with PTSD benefits from a more accepting and accommodating view of the memories of the event, as well as the anxiety and the fear (Tull, 2011; Walzer, Westrup & Hayes, 2005; Friedman, Keane & Resick, 2010; United States Department of Veterans Affairs, 2011).

EFT theory

The theory behind EFT is that negative emotions are caused by disturbances in the body's "energy field" (meridian system). Tapping on the meridians at acupuncture points while thinking of a negative emotion is said to alter the body's energy field restoring it to "balance." No matter how it works, the result is that just thinking about the problem does not provide the same emotional response as when you at the same time expresses an affirmation aimed at accepting yourself. Then you change the attitude to the problem. EFT may therefore be a good help in accepting the unacceptable, i.e. a life with a traumatic experience.

EFT and PTSD

It is impossible to rewrite a past event, but it is possible to change an individual´s perception of traumatic events. Those with PTSD often find themselves triggered by small, apparently innocent stimuli. It might be getting caught up in a crowd, feeling a particular smell or hearing a special sound. This may set off flashbacks, anger, fear, panic or depression. EFT has demonstrated promising results for PTSD. EFT treatment doesn´t mean that the memories disappear. They simply lose the emotional content. With EFT it is allegedly possible to discharge memories without re-traumatizing the client/patient (Nelson, 2011a, 2011b; Feinstein, 2008).

There are lots of case reports about EFT for PTSD and some studies. Church, Geronilla and Dinter (2009) report a decrease in symptom severity of 40% ($p<.001$) among veterans from Iraq and Afghanistan. Anxiety decreased 46% ($p<.001$), depression 49% ($p<.001$) and PTSD 50% ($p<.001$). In another study of veterans Church (2009) reports that after EFT treatment the group no longer scored positive for PTSD. These gains were maintained at the 90-day follow-up. Swingle, Pulos and Swingle (2005) have done brainwave assessments before and after EFT treatment. The clients who sustained the benefit of the EFT treatments had increased 13-15 Hz amplitude over the sensory motor cortex, decreased right frontal cortex arousal and an increased 3-7 Hz/16-25Hz ratio in the occiput. Karatzias et al. (2010) have compared EFT with EMDR (Eye Movement Desensitization and Reprocessing). Both interventions produced significant therapeutic gains at post-treatment follow-up in an equal number of sessions and similar treatment effect sizes were observed in both treatment groups. However, a slightly higher portion of the patients in the EMDR group produced substantial clinical changes compared with the EFT group. Gary Craig, the developer of EFT, has published a book "EFT for PTSD" in which he conveys his experience from practicing EFT on traumatized individuals (Craig, 2008).

Aim of the study

Earlier the first author has studied the effect of an EFT-program administered via the Internet for the treatment of individuals with fibromyalgia (Brattberg, 2008). The aim of this study was to examine if the same Internet-administered EFT-program leads to increased acceptance and reduced anxiety, depression, dissociation, catastrophic thoughts and PTSD-score in individuals diagnosed with PTSD.

Ethical aspects

The study was approved by the Regional Ethics Committee Stockholm (Dnr 2010/349-31/2).

Methods

Subject recruitment

Individuals referred to the Crisis and Trauma Center, Danderyds Hospital, Stockholm, Sweden, 11 on the waiting-list and 14 in treatment, were included in the study. They all scored above 44 on the PTSD-checklist (PCL-C) (Weathers, Husaka & Keane, 1991). Totally 25 patients, 19 women and 6 men between the ages 21 and 59 (mean 40, SD 9.9), started the Internet treatment program. Participants confirmed their informed consent by sending in the 8 completed questionnaires also distributed via the Internet. The majority reported multiple trauma experiences (Table 1).

Table 1. Trauma experiences in the study group (n=25).

Trauma	**Number of participants**
Accident/disaster	1
Physical assault	2
Sexual assault	2
War experience	1
Physical and sexual assault	8
Accident/disaster and physical assault	2
Accident/disaster and physical and sexual assault	7
Accident/disaster and physical and sexual assault and war experience	2

Intervention

The basic Emotional Freedom Technique involves holding a disturbing traumatic memory or emotion in mental focus and simultaneously using the fingers to tap on a series of 13 specific points on the body (face, upper body, hand) that correspond to meridians used in Chinese medicine. The treatment has three steps: the *setup phrase*, the *tapping* and the *gamut procedure*. The aim of the setup phrase is acceptance and affirmation. A recommended setup affirmation phrase is, “Even though I have this experience, I deeply and completely accept myself.” The setup phrase is said when rubbing the “sore spot” located in the upper left or right portion of the chest (alternatively, the “karate point” located at the outer end of the fifth metacarpal bone can be tapped). This statement sets the tone for the tapping. It is not necessary to believe in the setup phrase, but it is necessary to express it, preferably aloud, to oneself (Craig, 2010). While tapping the remaining 12 points three to four times each, the reminder phrase (a short version of the affirmation) is repeated. The “gamut procedure” involves performing nine “brain stimulating actions” (eyes closed, eyes open, eyes hard down right while holding the head steady, eyes hard down left while holding the head steady, roll eyes clockwise, roll counterclockwise, hum two seconds of a song, count rapidly from one to five, hum two seconds of a song again) while tapping the “gamut point” on the back of the hand.

Besides basic information about the study, the information and instructions consisted of four documents, a log register form and some Youtube-films in different languages dealing with EFT, all presented via the study’s home page. The documents, which were chapters from the

book *To Accept the Unacceptable* (Brattberg, 2006), had the following titles: Accepting the Unacceptable, Energy Psychology, Training Program for Energy Tapping, To Dare, Being Willing to Choose.

The program lasted for four weeks. For every training session the participants were asked to register the severity of the treated problem or symptom on a numeric scale from 1 to 10 (1=no problem, 10=severe problem). Every day during the study period they had the possibility to e-mail or phone the study leader, or ask questions in the course forum on the Internet. Medication was kept constant during the trial.

Assessment

At the beginning of the study, and after four weeks at its conclusion, the participants filled in the following questionnaires:

1. Life Event Checklist [LEC] (Gray, Litz, Hsu, & Lombardo, 2004)
2. PTSD-checklist [PCL-C] (Weathers, Huska, & Keane, 1991)
3. Anxiety and depression [HCS-25-S] (Derogatis & Leonard, 1974)
4. Somatoform Dissociation Questionnaire[SDQ-5] (Nijenhuis, Spinhoven, van Dyck, van der Hart, & Vanderliden, 1997)
5. Dissociative Experiences [DES-T] (Leavitt, 1999)
6. Self-rated function [PSOM-S] (Horowitz, Adler, & Kegeles, 1988; Adler, Horowitz, Garcia, & Moyer, 1998)
7. Coping Strategies Questionnaire [CSQ] (Jensen & Linton, 1993)
8. Chronic Pain Acceptance Questionnaire [CPAQ] (Mc Cracken, Vowles, & Eccleston, 2004)

In CSQ and CPAQ the responders were asked to replace pain to their most bothering symptom, i.e. anxiety, panic, “pain in life”.

Statistical analysis

Variables were analysed with repeated measures ANOVA if homogeneity test at baseline was non-significant (Levene’s test), otherwise non-parametric tests were used. Sperman rank sum test was used to test the pre-post difference in PTSD-score, anxiety and depression against the number of login-days for each participant, as well as messages by e-mail, which was the preferred activity of participation that could be measured.

Results

Of the 25 who started the Internet intervention one, despite reminders by mail, phone and SMS, did not fill in the questionnaires after the course. The number of days they have logged in to the 28-day-course varied between 1 and 19 (mean 7, SD 4.3). Some of those with few logins may have printed out the course documents. Posts in the discussion forum were almost absent. The participants who had questions preferred to mail the course leader. Results measured by the self-rating instruments are shown in Table 2.

Table 2. Results from a four week long intervention via the Internet (n=24).

Test	**Pre**		**Post**		**P-value**
	Mean	SD	Mean	SD	
PTSD (PCL-C)	63.4	9.6	57.2	17.3	0.01*
Anxiety (HCS-25)	2.7	0.7	2.6	0.7	0.03*
Depression (HCS-25)	2.9	0.7	2.7	0.8	0.02*
Somatoform dissociation (SDQ-5)	9,9	5.2	9.3	4.8	0.2
Dissociation experiences (DES-T)	19,6	22.4	17.7	20.0	0.3
Self-rated function (PSOM-S)	7.4	4.2	8.3	4.1	0.03*
Acceptance (CPAQ)	49.2	20.2	56.1	21.8	0.008**
Catastrophic thoughts (CSQ)	19,8	8.1	17.8	6.8	0.1
Control (CSQ)	4.8	2.5	5.3	2.7	0.2

* $p<0.05$ ** $p<0.01$.

Two participants reported normal values in all screenings instruments after the intervention. There were no statistically significant correlations between the improvements in PTSD-score, anxiety and depression when tested against number of login-days or number of e-mails sent to the course leader. However, those who seemed to be more engaged in the course, i.e. mailed more often to the course leader, also showed the greatest improvement. Effects sizes of the intervention were 0.253 for PTSD using the PCL-scale, 0.180 for anxiety using Hopkins symptom checklist-25, and 0.225 for depression. Thus the effect sizes of the intervention were modest. It turned out, however that the group with the highest change in the acceptance scale also had the highest reduction in PTSD score.

Qualitative results

The following quotes are from the mail conversation with the course leader:

“I have focused tapping of acceptance, which has been a major problem for me. Today, I accept the fact that I am sick and that it will take time and energy to get out of this. I have achieved a certain serenity.”

“During the course weeks my basic mood was higher. I believe that EFT is a contributing factor. I have not had a ‘full-blown’ flashback during the course either.”

“I really feel that this EFT course is a beginning of a major change. It seems that the flow of things that I need to tap on is enormous, the list is getting longer all the time. It feels like a lifetime´s work.”

“I think there has been a clear change. Just when I tap, I feel hardly anything. Maybe I become a little calmer if I tap on anxiety. But I think the overall condition has improved, maybe I have the same stomach ache as before, but I accept it actually more.”

“I have discovered new fears inside me during the four week course. It is both pleasant and unpleasant. I have had great benefit from the course, have learned new things and to look at my problems in a different way.”

“This course has been an ‘aha’ experience. I've got a large opening into the future and I´ve learned how to deal with things that are tough. I have become more perceptive and happier during the tapping. I am so happy about this transformation and I know that it will continue in the future.”

“I feel better now. It is because of the course. I have learned to accept myself and my life situation. Anxiety comes and goes for me, but then I use the tapping as an aid. Otherwise, I have not changed anything in my life, so it's the course that has improved my self-confidence.”

Discussion

The study involved two major problems, recruitment difficulties and the participants’ motivation and self-discipline for self-studies. They have all been referred to a specialist clinic for trauma patients, which means that they with few exceptions were complicated multi-traumatized cases. Individuals in such bad conditions mostly lack motivation, and self-discipline. To bridge that problem the course leader has been easily available via phone, mail and the course module every day during the course. Some participants have also commented on this: “I admire your enthusiasm and your commitment. Such as you should the world have more of. You are passionate about what you do. You are an inspiration.” ”Thanks for your efforts and for that you care about us.” To engage a good role model with PTSD who has benefited from EFT as a motivator would be worth a try. It would be of interest to study EFT via the Internet among individuals who are not as complicated cases as the participants in this study.

Despite or thanks to EFT, there were improvements among those who used energy tapping, i.e. put words on the issue, expressed a wish of acceptance; and performed the motor activity employed in the protocol. The PTSD-score was reduced in many participants. It is, however, impossible to know whether the positive results are due solely to practiced EFT or if other parallel treatment has been of significance.

The results of this study do not make it possible to establish which effect was primary, nor which mechanisms were involved. However, McCracken & Eccleston (2003) have shown that acceptance of chronic pain is associated with less pain. As acceptance is central in EFT, acceptance of the trauma experiences probably have led to reported reduction in anxiety, depression and PTSD-score. If that is the case the question is: Why does the EFT procedure lead to acceptance? The setup phrase in EFT is an affirmation dealing with acceptance, which is reinforced by tapping. Earlier studies have shown relationships between affirmations of adaptive and maladaptive statements and outcome (Peden, Rayens, Hall, & Grant, 2005; Karpiak &Benjamin, 2004; Curtin, Mapes, Petillo, & Oberley, 2002). Thus, acceptance of the trauma experience is probably the key factor in the observed results.

In view of the relatively modest effects sizes it must be considered that the intervention was short, and that most participants did not seem to be very active. The explanation for this could be skepticism, suspiciousness, or low level of experience with computers.

In a previous study of work-related exhaustion the participation was much higher, and participants accessed the discussion forum frequently. In that study, it turned out that many

participants had traumatic experiences, and that they also endorsed PTSD symptoms that were amenable to treatment with the EFT procedure. In the present study, participants were reluctant to participate on the discussion forum and only participated sparsely in e-mail contact with the study leader. In several cases, it was also necessary to remind the participants in order to obtain their self-ratings at follow-up.

In view of these findings, it is concluded that the intervention seemed to work well for the participants who took it seriously and were able to engage in the study. Therefore, we suggest that in further studies the intervention should be delivered in a group format, with the possibility of individual coaching, e.g. via internet, telephone calls, or individual booster sessions.

In a forthcoming random study we plan to increase the participants´ motivation and reduce the time bias by a week-long intensive EFT-course. We will also add some physiological variables (qEEG and evoked potentials) to the study protocol.

Conclusion

The sample size was small. The motivation and engagement were in some individuals very low. Therefore the results are surprisingly good but they have to be interpreted with caution. The next research step would be a randomized study embracing a much larger group of participants, and better motivate them to daily EFT training. As EFT is a simple, quick, inexpensive, accessible self-administered method without apparent negative side effects and with no need to re-traumatize the client/patient and which can even be taught by the Internet. EFT as an adjuvant treatment in patients with post-traumatic disorder is an interesting development that includes acceptance, exposure, and behavioral activation.

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