

The Effect of EFT (Emotional Freedom Techniques) on Psychological Symptoms in Addiction Treatment: A Pilot Study

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Authors' contributions

This work was carried out in collaboration between all authors. Author DC designed the study; the author AB performed the statistical analysis, and wrote the primary draft of the paper. All authors read and approved the final manuscript.

Research Article

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ABSTRACT

Objective: Studies have found a frequent co-occurrence of psychological symptoms such as anxiety and depression with addiction. This pilot study examined the effect of EFT (Emotional Freedom Techniques), a widely practiced form of energy psychology, on 39 adults self-identified with addiction issues attending an EFT weekend workshop targeting addiction.

Measures: Subjects completed the SA-45, a well-validated questionnaire measuring psychological distress. It has two global scales assessing intensity and breadth of psychological symptoms and 9 symptom subscales including anxiety and depression. The SA-45 was administered before and after the workshop. Twenty-eight participants completed a 90-day follow-up.

Results: A statistically significant decrease was observed in the two global scales and all but one of the SA-45 subscales after the workshop, indicating a reduction in psychological distress (positive symptom total -38%, $P < .000$). Improvements on intensity and breadth of psychological symptoms, and anxiety and obsessive-compulsive subscales were maintained at the 90-day follow-up ($P < .001$).

Conclusion: These findings are consistent with those noted in studies of other populations, and suggest that EFT may be an effective adjunct to addiction treatment by

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reducing the severity of general psychological distress. Limitations of this study include a small sample size, lack of a control or comparison group, and attrition between primary and follow-up data points.

Keywords: Addiction; EFT (Emotional Freedom Techniques); depression; anxiety.

1. INTRODUCTION

The association between mood disorders such as depression and anxiety, and addiction, has been repeatedly demonstrated [1]. However, mental health and drug treatment systems tend to treat one disorder only, or one disorder at a time [2]. Further, addiction treatment is typically delivered in an acute-care format ignoring the long-term, multi-faceted nature of recovery. In reality, addiction has been characterized as a chronic, relapsing disorder [3]. Substance abusers often report using substances to self-medicate psychological symptoms, while mental health issues may exacerbate substance abuse [4].

Emotional Freedom Techniques (EFT) is a novel intervention combining elements of exposure therapy, cognitive behavioral therapy, and somatic stimulation. The purpose of this pilot study was to examine the effect of EFT on psychological symptoms in a sample of persons self-identified as having addiction issues. Many are also practitioners in the addiction treatment field. Research reviews indicate that EFT is an effective treatment for anxiety, depression and other psychological disorders [5-8]. Over five thousand case reports demonstrate the effect of EFT on various psychological and physical symptoms (www.EFTuniverse.com). EFT studies utilize treatment time frames ranging from one to six sessions, and those that include follow-ups note that the effects of EFT persist over time [5]. A recent review of energy psychology studies published in the American Psychological Association (APA) journal *Review of General Psychology* evaluates EFT studies against the APA Division 12 (Clinical Psychology) Task Force guidelines for empirically validated treatments [6] and finds that:

The 18 randomized controlled trials in this sample were critically evaluated for design quality, leading to the conclusion that they consistently demonstrated strong effect sizes and other positive statistical results that far exceed chance after relatively few treatment sessions. Criteria for evidence-based treatments proposed by Division 12 of the American Psychological Association were also applied and found to be met for a number of conditions, including PTSD.

The physiological mechanisms of action of EFT have been elucidated in a number of studies. A triple-blind randomized controlled trial of 83 subjects examined their levels of the stress hormone cortisol [7]. Cortisol is a “master hormone” regulating many other physiological processes, and an objective biomarker of stress. The study compared a group receiving a single EFT session with two other groups. One of these received conventional talk therapy, while the second control group simply rested. Analysis revealed that cortisol declined by 24% in the EFT group ($p=.03$), while anxiety and depression symptoms dropped three times as much as in the other two groups ($p=.001$). EFT uses elements of established protocols such as cognitive behavior therapy, and exposure therapy, which an evidence review by the US government’s Institute of Medicine found to be efficacious for traumatic stress [9]. To these EFT adds the manual stimulation of acupuncture points or acupoints. This somatic stimulation is hypothesized to enhance the effectiveness of established therapies [6].

Cortisol levels correlate with EEG patterns, especially the relative levels of beta and alpha frequency brain waves; a predominance of high frequency beta indicates anxiety, fear, and other traumatic emotional states [10]. EEG studies of subjects receiving EFT and other forms of energy psychology note the regulation of these frequencies [11,12]. Normalization of the EEG patterns of subjects receiving energy psychology in both the frontal lobes and the hindbrain have been observed in a shorter time frame than that required by cognitive behavioral therapy [13].

EFT was developed by an engineer trained at Stanford University named Gary Craig. Craig abbreviated methods used in Thought Field Therapy, an earlier energy psychology method which used elaborate diagnostic and treatment protocols [14]. Craig came to the conclusion that a brief, standardized protocol could reduce general stress levels without the need for lengthy diagnoses, and organized these points into an easily-administered method. EFT may be self-administered or administered by a coach or therapist. It is uniformly applied, with *The EFT Mini-Manual* [15] available free online.

The combination of a short-term intervention, easy to master technique, and immediate results contribute to the hypothesis that EFT may be an effective tool for persons in addiction recovery or treatment. The present study sought to examine the immediate and long-term effects of EFT on psychological distress symptoms in a sample of persons with self-identified addiction issues, some of whom were also addiction treatment practitioners.

2. METHODS

2.1 Participants

Study participants were a convenience sample drawn from the weekend workshop, Healing the Cycle of Addiction, conducted by four EFT Masters specializing in the treatment of addiction [16]. The workshop was held in Los Angeles, CA, in January, 2008, and was geared toward practitioners specializing in the treatment of addiction and individuals wishing to address their own addiction issues. Data were gathered immediately before and after the workshop, and 90-days later. The study was reviewed for human subject protections by the ethics committee of Soul Medicine Institute, and all participants provided informed consent. The investigators completed CITI human subjects protection training, and the primary investigator is licensed by the Association for Comprehensive Energy Psychology (ACEP license CEHP # 2016).

2.2 EFT Intervention

EFT can be regarded as an exposure therapy combining cognitive and somatic elements. The cognitive element involves self-assessment of the degree of distress, and the pairing of an exposure statement and a self-acceptance statement. The degree of distress is evaluated by the subject on an 11 point scale, with 10 representing the maximum distress possible. This is referred to as the Subjective Units of Distress or SUD and indicates symptom severity. The pairing of the exposure and the self-acceptance element is referred to as the "setup statement." A typical setup statement is of the simple structure: "Even though I have (stated problem), I fully and completely accept myself." A specific addiction example might be, "Even though I'm a shopping addict, and can't drive by the mall without buying something, I fully and completely accept myself." The somatic portion of an EFT treatment consists of the subject or therapist rubbing or tapping 12 acupressure points on the body

with one or two fingertips. Five points are on the head, 2 are on the torso, and 5 are on the hand. After assessing SUD, an EFT treatment begins by repeating the setup statement three times while tapping the points 5-10 times. This is referred to as a "round" of "tapping." After a round of EFT tapping, SUD is reassessed. If the number has not gone down, more rounds of EFT may be performed until the SUD number is at or near zero.

The manner in which EFT was taught at the workshop varied with presenter. One presenter demonstrated EFT techniques with workshop volunteers. Another presenter gave audience members materials for assessing adverse childhood experiences. During the presentation, she had subjects self-administer EFT several times using setup statements specifically designed to counteract the negative effects of these effects. The other two presenters explained the application of EFT to addictive cravings. Participants described a variety of addictive cravings for substances including chocolate, food, tobacco, alcohol, prescription drugs, and recreational drugs.

2.3 Measures

The SA-45 is short form of the Derogatis Symptom Checklist (SCL-90), and contains 45 items. It is reliable and valid [17]. It contains two major scales which record the severity of symptoms (Global Severity Index; GSI) and the breadth of symptoms (Positive Symptom Total; PST) and nine subscales: anxiety, depression, obsessive-compulsive behavior, phobic anxiety, hostility, interpersonal sensitivity, paranoia, psychoticism, and somatization. Raw scores are converted to T-scores based on age and gender-normed data for non-clinical populations. Scores above 60 are considered clinical.

3. RESULTS

3.1 Participant Characteristics

A total of 100 people attended the workshop. Of these, 39 completed the informed consent form and the pretest and posttest SA-45s (39%). Twenty-eight of the study participants (72%) completed the 90-day follow-up. The sample was predominantly female (N=28; 71.8%) with an average age of 54 years old (range 35-78 years old).

3.2 Follow-up Data Group Comparisons

Chi-square and t-test analyses were conducted to compare participants with and without follow-up data. There was no difference in age between the two groups ($t(37)=-1.1, p<.26$); however gender was significant ($\chi^2=5.3, p<.022$). Females were much more likely to complete the 90-day follow-up (82% vs. 18%). No significant group differences were found for the SA-45 scales with the exception of the anxiety subscale ($t(34.9)=2.2, p<.033$). Participants without follow-up data were more anxious than those with follow-up data collection (no follow-up Mean (SD): 63.0 (4.9) vs. have follow-up Mean SD: 57.7 (10.0)).

3.3 Pre-Post SA-45 Changes

A General Linear Model (GLM) repeated measures analysis of variance was conducted on each of the SA-45 subscales, GSI and PST with follow-up data (yes/no) as the between subjects group variable. Gender was included as a covariate in the models. No significant time by follow-up group interactions were found, however statistically significant time effects

($p < .05$) were found for the two global indices and all subscales with the exception of phobic anxiety (Table 1).

3.4 Follow-up SA-45 Changes

GLM repeated measures analysis of variance was conducted on the SA-45 subscales, GSI and PST to examine changes over time for the 28 subjects with complete data.

Statistically significant effects for time were found for the global scales, the GSI and PST, and the anxiety, obsessive-compulsive, somatization, interpersonal sensitivity and paranoid ideation subscales. Posthoc Tukey tests revealed a statistically significant difference between the pretest and both posttest scores for GSI, PST, anxiety, and obsessive-compulsive scales. Tukey rather than Scheffe tests were undertaken to minimize the possibility of Type I error. This finding, coupled with the lack of statistical significance between the posttest and 90-day follow-up score, indicates that the gains observed immediately following the workshop were maintained over time. The posttest for somatization was significantly different from the pretest and 90-day follow-up score ($p < .05$), indicating that the decrease in symptom level was not maintained at follow-up. A statistically significant decrease in interpersonal sensitivity was found at the 90-day follow-up ($p < .05$); but not at the posttest (Table 2; Fig. 1).

Table 1. Pretest and posttest means and standard deviation for SA-45 N=39

Variable	Pretest	Posttest	F(1,36)	Sig
Anxiety	59.18 ±9.14	53.10 ±6.46	18.94	.000
Depression	55.07 ±7.62	53.23 ±6.23	5.54	.024
Obsessive-compulsive	59.49 ±7.90	51.23 ±6.97	36.9	.000
Somatization	57.51 ±7.75	50.95 ±6.51	20.7	.000
Phobic anxiety	61.92 ±5.83	60.21 ±3.32	3.90	.056
Hostility	57.28 ±5.50	54.67 ±3.33	10.66	.002
Interpersonal sensitivity	59.72 ±7.05	55.18 ±7.02	24.44	.000
Paranoid ideation	55.03 ±8.41	50.79 ±6.20	10.05	.003
Psychoticism	61.77 ±4.58	60.21 ±3.34	11.07	.002
General Symptom Index	57.28 ±8.80	49.49 ±8.08	39.57	.000
Positive Symptom Total	57.56 ±8.81	49.79 ±8.43	37.35	.000

Table 2. Pretest, posttest, and 90-day follow-up means and standard deviations for SA-45 N=28

Variable	Pretest	Posttest	90-day Follow-up	F(2,54)	Sig
Anxiety	57.68 ±10.02 ^a	52.57 ±6.50 ^b	53.54 ±5.91 ^b	6.72	.002
Depression	55.07 ±7.62	52.57 ±6.33	52.89 ±5.36	2.36	.105
Obsessive-compulsive	59.14 ±8.50 ^a	51.11 ±7.53 ^b	53.50 ±7.01 ^b	19.24	.001
Somatization	56.79 ±8.32 ^{a,c}	50.64 ±5.53 ^{b,d}	54.32 ±6.26 ^c	17.38	.001
Phobic anxiety	61.86 ±6.15	60.32 ±3.66	59.64 ±3.11	2.68	.078
Hostility	56.71 ±5.68	54.82 ±2.79	55.25 ±2.84	2.89	.064
Interpersonal sensitivity	58.5 ±6.93 ^a	55.18 ±7.10	53.57 ±6.33 ^b	6.17	.004
Paranoid ideation	53.64 ±8.27	50.50 ±6.33	51.18 ±7.65	3.16	.050
Psychoticism	61.25 ±4.66	60.21 ±3.34	59.64 ±2.42	2.89	.064
General Symptom Index	55.82 ±9.31 ^a	49.25 ±7.84 ^b	50.04 ±7.81 ^b	15.23	.001
Positive Symptom Total	55.96 ±9.15 ^a	49.43 ±8.13 ^b	51.07 ±9.53 ^b	11.77	.001

Posthoc Tukey tests $a > b$, $P < .05$; $c > d$, $P < .05$

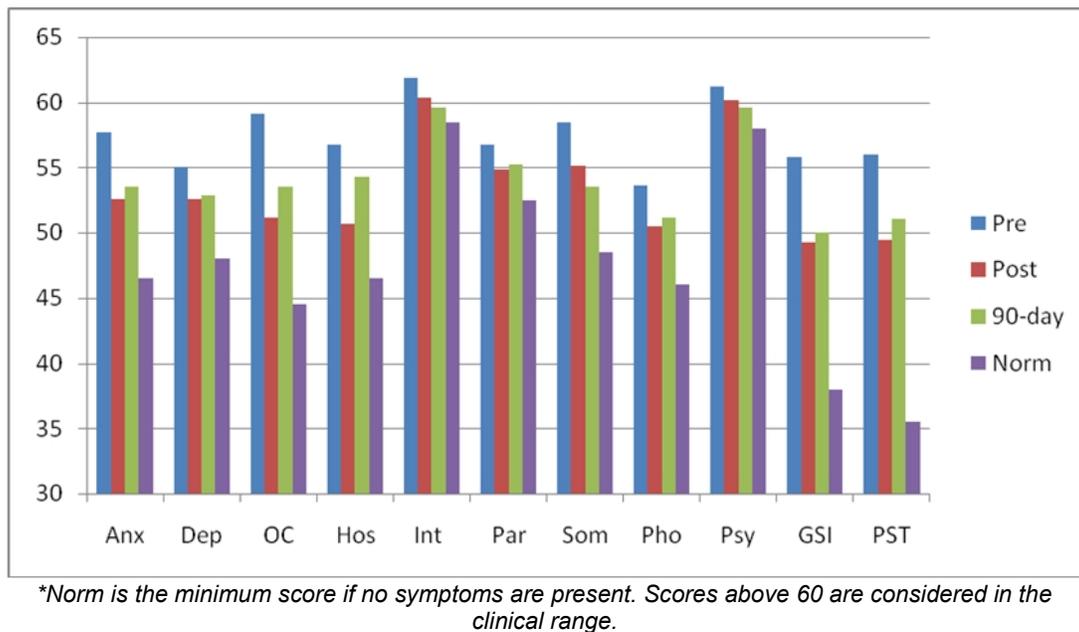


Fig. 1. Pretest, posttest, and 90-day follow-up SA-45 scales*

4. DISCUSSION

The purpose of this pilot study was to examine the effects of EFT on psychological distress in a sample of persons with self-identified addiction issues. Improvement in overall psychological distress was observed with improvements maintained at the 90-day follow-up. This study indicates several potential clinical applications of EFT. Reducing psychological symptoms may be viewed as a form of relapse prevention for persons in addiction treatment or recovery. Psychological distress often persists during recovery and may lead to relapse [18]. Participants in this study self-identified as having addiction issues, suggesting EFT may be a resource for persons in recovery to handle ongoing psychological distress. Integrating treatment for psychological symptoms into addiction treatment has also been widely advocated [19]. Future studies might examine EFT as an adjunct to addiction treatment.

High rates of childhood abuse and maltreatment have been found in persons with substance disorders [20]. The impact of childhood abuse is experienced across physical, psychological, and social domains and often persists for many years [21]. One aspect of this workshop was the application of EFT to the treatment of adverse childhood experiences, and all participants used EFT on these as a group. EFT has been found to be efficacious for treating the symptoms of psychological trauma after disasters [6] and war [22].

No adverse events were reported during the workshop. This is consistent with other published reports indicating that EFT produces a reduction in client distress during the recall of traumatic memories, lessening the danger of retraumatization [22].

The delivery of any therapy in a group format is also cost-effective. In clinical settings, such as drug treatment programs, homeless shelters and veterans' centers, a group intervention can be delivered more rapidly and at much lower cost than individual sessions. Whether EFT

group therapy is an adjunct to individual therapy or a supplement to group addiction treatment, reduction in psychological symptoms supports recovery efforts.

The study had a number of limitations. There was no comparison or control group. The sample was predominantly female, limiting its generalizability to males. Only 39% of the workshop attendees completed the informed consent form and initial assessment, with attrition further limiting the number of follow-up responses available for data analysis.

For the addiction treatment practitioner, EFT training may fill several gaps. Researchers have advocated cross-training in mental health treatment for clinicians treating persons with addiction disorders [23]. Unlike other mental health techniques that require extensive training, EFT is a straight-forward technique that practitioners can master in a short time-frame [24]. High levels of burnout, psychological distress, and correspondingly high turnover rates are common among addiction counselors [25]. EFT may prove to be an effective tool in handling the stress and burnout associated with working in the addiction field.

CONSENT

Written informed consent was obtained from the participants.

ETHICAL APPROVAL

All authors hereby declare that all experiments have been examined and approved by the appropriate ethics committee and have therefore been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki.

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COMPETING INTERESTS

The first author derives income from publications and presentations relative to the technique presenter. The second author declares no conflicts of interest.

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