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# **Emotional Freedom Techniques (EFT) as a practice for supporting chronic disease healthcare: A practitioners' perspective**

## **Abstract**

**Purpose:** The objective of the present study was to explore Emotional Freedom Techniques (EFT) practitioners' experiences of using EFT to support chronic disease patients. This was part of a larger study exploring chronic disease patients' and EFT practitioners' experiences of using EFT to support chronic disease healthcare.

**Methods:** A qualitative approach was deemed suitable for this study. Eight practitioners were interviewed using semi-structured interviews via telephone or Zoom (an online video-conferencing platform). Interviews were transcribed verbatim and data was analysed using Interpretative Phenomenological Analysis methodology.

**Results and conclusion:** This article present two super-ordinate themes which explore application of EFT for addressing emotional issues faced by chronic disease patients, and for management of physical symptoms, respectively. Chronic disease patients may benefit from a holistic biopsychosocial, patient-centred healthcare approach. EFT offers potential as a technique that may be used by health practitioners to support the psychosocial aspect of chronic disease healthcare.

*Keywords: Emotional Freedom Techniques (EFT); chronic disease; Interpretative Phenomenological Analysis (IPA); emotions; biopsychosocial model*

## **Introduction**

For most of the 20<sup>th</sup> century, the conventional biomedical model of health and illness was based on a separation of the mind and the body. The biomedical model viewed disease in a linear fashion. According to this model, diseases have a specific (usually single) biological cause, and a specific biomedical treatment. In the 1970s, George Engel suggested that disease must be viewed from a systematic approach, taking psychological and social aspects of an illness into account, in addition to the biomedical dimension. Engel called this the 'biopsychosocial model' (1). The biopsychosocial model is based on the premise that psychological and physiological processes are closely inter-linked. Interactions of several biopsychosocial factors thus promote illness (2). Consequently, to restore and maintain health, a number of factors must be considered, including biological, psychological, social, environmental, and spiritual elements (2, 3).

The biopsychosocial model of health suggests that chronic disease patients may benefit from more 'holistic' healthcare that focusses not only on the biomedical dimension and the cessation of physical symptoms, but also on psychological and social aspects, such as enhancement of overall well-being (4), and improvement of their ability to engage in meaningful social, civic and economically functional lives (5, 6). For example, chronic illnesses (e.g. pulmonary diseases) can hamper patients' ability to perform day to day tasks, such as continuing paid employment (7). The inability to undertake paid employment, and subsequent financial stress, can leave people questioning their social identities, and experiencing reduction in their self-esteem and consequent sense of loss. In this eventuality, the absence of psychological and social support can severely affect patients' quality of life and coping ability and even result in

comorbidities (7). As such, providing psychological support to chronic disease patients may be desirable, even necessary for effective healthcare.

Anthony (1993) argued, in the context of chronic mental illness, that a person can ‘recover’ from a disease, even though the disease has not been cured (8). This conceptual formulation of ‘recovery’ encompasses hope, inclusion in society, healthy relationships and an overall quality of life that the patient deems satisfactory (8). As such, medical assistance to promote ‘recovery’ should stretch beyond curing a condition, to the enhancement of social and occupational life, symptom management, and overall patient wellbeing (9). While the aforementioned model of recovery was developed with the view of chronic mental illness management, Harvey and Ismail (2008) argue that the above recovery model is also applicable to chronic physical illnesses (10). Harvey and Ismail (2008) suggest that psychiatric problems interact with physical health conditions, and thus providing psychological support is crucial for effective management of physical health conditions (10).

A contemporary psychotherapeutic intervention, called Emotional Freedom Techniques (EFT), is being administered to support chronic disease patients on their recovery journeys, to complement biomedical healthcare, and enhance patients’ quality of life and promote greater emotional well-being (11, 12, 13, 14).

### ***Emotional Freedom Techniques (EFT)***

Emotional Freedom Techniques (EFT), also known as ‘Tapping’ is a therapeutic tool, which combines principles of Western psychotherapy with Chinese acupuncture. Craig and Fowlie (1995) and subsequently Church (2013) have described the process of EFT (15, 16). EFT requires a subject to gently tap on certain acupuncture points on his/her face and upper body with fingertips, while being psychologically exposed to a specific

emotional trigger, such as a distressing memory, negative emotion (e.g. anger, fear), object of phobia etc. (17). The subject self-reports an initial perceived distress rating, also known as a 'subjective unit of distress' (SUD) score on a scale of 0 to 10, where a score of '0' indicates no distress, and a score of '10' indicates high distress. Subsequently, the subject taps on certain acupoints on the face and upper body, while focusing on the distressing emotional trigger, and concurrently voices statements of self-acceptance, e.g. 'Even though, I am feeling this anger, I accept myself'. The process is repeated, until the SUD score is significantly reduced. Other cognitive strategies may be employed by practitioners and users to supplement the aforementioned process (15, 16).

Studies and review articles investigating the efficacy of EFT treatment for a variety of psychological and physical health problems have appeared in peer-reviewed medical and psychology journals. Meta-analyses of clinical trials indicate a large treatment effect of EFT treatments for anxiety, depression, and PTSD symptoms (18, 19, 20). Several studies using quantitative data have also been conducted investigating the effects of EFT on physical chronic health problems such as tension headaches (11), obesity (21), traumatic brain injury (12), chronic pain (13), and psoriasis (14). However, there is a paucity of studies exploring users' experiences of EFT using qualitative data.

There currently exist a variety of proposed hypotheses in relation to the mechanism of action in EFT. Diepold and Goldstein (2009) suggest that EFT has potential effects on the body's physiological systems that regulate stress, emotional intensity and associated neural transmission frequencies (22). Stapleton, Sheldon and Porter (2012) indicate that EFT appears to decrease activity in the amygdala, leading to calming of the 'fight, flight, freeze' threat response to emotional triggers (23). Brattberg (2008) further suggests that similar to Cognitive Behavioural Therapy and Mindfulness, EFT relies on

the premise that acceptance of, rather than resistance to, a particular condition can reduce suffering (24).

### ***Study Aim***

As previously mentioned, there is paucity of literature investigating users' experiences of EFT using qualitative data. This article explores EFT practitioners' experiences of using EFT to support physical chronic disease patients. This article is part of a broader study that explored EFT practitioners' and chronic disease patients' use of EFT for supporting physical chronic disease healthcare.

The results from the broader study span four main areas: EFT practitioners' experiences of using EFT to support chronic disease healthcare (discussed in the present article), patients' constructions of 'illness', patients' constructions of 'recovery', and the delivery of EFT therapy via tele-mental health applications and self-administration. The latter aspect is explored in Kalla (2016) (25), while the remaining findings are yet to be published as of the time of submission of the present article.

### ***The Practitioner Experience in EFT***

Traditionally psychotherapeutic models were based on the notion that the therapist and the therapeutic process are the most important factors in the client's healing (26). For example, Grenavage and Norcross (1990) found that the client's primary role was considered to comprise the act of seeking help and have a positive expectation/hope for the therapeutic process (27). Bohart (2000) argues that the client is an active self-healing agent who receives the therapist's input and adapts it to achieve his her/own ends (26). According to Bohart (2000), the therapist is a facilitator for the client, and therapeutic process is best focused on collaboration and dialogue (26).

In the EFT approach, the therapeutic process is usually guided by the client's emotional and thought trail (28). The therapist guides the tapping process based on what presents for the patient, often regardless of the apparent connection or lack thereof, to the target issue (28). This is also in line with the concept of 'free association' whereby a client is encouraged to freely share thoughts, emotions or memories that come to mind, irrespective of their coherence or relevance to the target subject matter. For example, while endeavouring to resolve fears associated with an illness diagnosis, if the client is reminded of a seemingly unrelated childhood event, the therapist will follow this thought/emotion trail and aim to resolve whichever memories or emotional triggers surface for the client (28).

In viewing the patient as an active self-healer and as possessing his/her own wisdom, an EFT therapist's experience may be considered intertwined with the client's experience. As such, in describing their own experiences of an EFT therapy session, the practitioners are likely to invoke their understanding of their patients' experiences during the session. Therefore, the focus of the current article is on the practitioners' understanding of how the therapeutic process impacted their clients.

### **Methodology and Methods**

A qualitative research orientation was deemed appropriate for the present study, because qualitative data offers a useful means of exploring research questions pertaining to human experiences (29). Among the various paradigms and traditions in qualitative research, is the approach of 'phenomenology'. Phenomenology is the study of structures of experience, or consciousness (30, 31). The understanding of phenomenology has evolved through the work of a number of philosophers and thinkers, among whom is the philosopher, Martin Heidegger (30).

Heidegger proposes the concept of interpretative phenomenology which suggests that humans are embedded in the context of their lifeworld (e.g. comprising objects, language, and relationships); thus humans' experiences are subjective, and depend on their own perspectives (30, 31). Phenomenologists, over the years, have come to a 'worldly' approach to the study of lived experience, one that aims to understand people's perspectival involvement with their meaningful, lived worlds.

A contemporary research methodology, Interpretative Phenomenological Analysis (IPA), was devised to enable the study of people's unique subjective experiences using an interpretative approach (31). IPA is phenomenological in that, it is concerned with the study of lived experience and hermeneutic in that it deems that knowledge or understanding of that experience can be accessed through an interpretative process on the part of both the researcher and the participant. IPA is also idiographic because it focuses on the detailed study of individual cases, which means that only a small number of participants are required, even appropriate (32).

IPA research also involves a 'double-hermeneutic' (33, p. 51) which implies a two-fold interpretative process. The participant tries to make sense of, and interprets his/her own experience, and subsequently, the researcher interprets the participant's account of his/her experience. The objective of IPA, is to explore context and meaning in order to enable a better understanding of the complexity of lived experience (34). IPA has been widely applied to studies which are underpinned by or related to the biopsychosocial model of health, including those exploring health practitioners' and patients' experiences (35). Therefore, in line with the study's aim to understand EFT practitioners' experiences, IPA was chosen as the methodological approach.

### ***Researcher positionality***

The first author, also the PhD researcher responsible for formulation of the broader research study, is a user of EFT, and had completed EFT practitioner training before the conceptualisation of the PhD research project. The second and third authors possess an interest in holistic health and the study of people's experiences. The last author is an EFT practitioner and researcher. Given the first and last authors' status as users of EFT, the current study may be considered as 'insider research'.

IPA acknowledges that it is not possible to completely remove the researcher from the research to maintain an entirely objective stance (36). Additionally, researchers' prior knowledge, life experiences and attitudes provide context to a study's findings (36). IPA is therefore considered suitable for insider research. Insider researchers can have various advantages, such as the ability to easily build rapport with participants, ease of communication given their knowledge of linguistic cues and "non-verbal cultural competence" (37, p. 204) and prior knowledge of issues and opportunities in the topic area (38). On the other hand, IPA also recognises that a researcher's insider perspective and prior knowledge may encumber the interpretation of participants' accounts (39). Reflexive processes can be used to counter some challenges of insider research. Further information on reflexivity in this study has been provided in the data analysis section.

### ***Sampling and Recruitment***

Given the idiographic nature of the IPA methodology, most IPA studies involve purposive sampling (33). In purposive sampling, researchers aim to find a well-defined homogenous group of participants for whom the research question will be relevant (33). Sample sizes are usually small, sometimes as little as five or six participants, since IPA studies generate rich, in-depth qualitative data. Purposive sampling involves selecting

participants with certain pre-decided characteristics, such that, in light of adequate context, a reasonably sound perspective on a given topic can be developed (34).

The overarching study, which this article was a part of, was approved by Monash University Human Research Ethics Committee. Participants were recruited through professional associations such as Association for the Advancement of Meridian Energy Techniques (AAMET), EFT Universe, Association for Comprehensive Energy Psychology (ACEP) and EFT Australian Practitioners Inc. (EFTAP).

Inclusion criteria were primarily related to qualifications and professional experience. Requirements were that EFT Practitioners were trained and certified through established professional bodies such as AAMET, EFT Universe, and ACEP, and have at least four years' experience practising EFT professionally. EFT practitioners tend to offer EFT therapy for a wide range of issues (e.g. weight loss, improving self-confidence, symptom management and healthcare), due to the generalisability of this technique. As such, for the purposes of this study, EFT practitioners were also required to have worked with a minimum of three clients with physical chronic diseases. Given that EFT is a relatively contemporary tool, placing other socio-demographic criteria such as location and gender, or restricting the 'type' of chronic diseases under consideration, would potentially, significantly reduce the number of eligible participants, making recruitment challenging. As previously mentioned, the participant sample in an IPA research study should ideally be homogenous (26). In the present study, despite diversity in socio-demographic traits, the participant sample is homogenous with regards to participants' use of EFT with chronic disease patients, their qualifications and training in provision of EFT therapy, and minimum years of experience practising EFT professionally.

Respondents to advertisements were screened by asking questions about their professional experience and qualifications via email or telephone. Individuals meeting

inclusion criteria were emailed an Explanatory Statement, pre-approved by the Ethics committee, outlining the research project, participation consent procedure, risks and benefits of participating, confidentiality agreement, data storage and dissemination, and withdrawal and complaints procedures. Upon reading the Explanatory Statement, participants signed a Consent Form, also pre-approved by the Ethics committee, consenting to participate in the study, and returned to the first author via email.

Eight EFT practitioners (six female, one male, and one non-binary), located across Australia (three), England (two), Spain (one), Canada (one) and Mexico (one), were interviewed for this study. Participants' names were changed to preserve confidentiality. Participant information is provided in Table 1.

Insert Table 1 here.

### ***Data collection***

Semi-structured interviews, a commonly used data collection tool in IPA studies (40), were used in the present research. Semi-structured interviews can be described as intentional conversations, which allow researchers to elicit detailed and targeted information from participants (31, 41). Given the geographical diversity of participants, interviews were also considered to be the most viable form of data collection. The practitioners were interviewed via telephone or Zoom (a video-conferencing platform). The interviews lasted between 60 – 120 minutes, with average time being about 80 minutes. Interviews were recorded using a smartphone application (in the case of telephone interviews) or directly through the video-conferencing platform's in-built recording functionality (Zoom).

Interview questions or prompts were formulated such that they enabled participants to freely and descriptively share their experiences. Practitioners were asked questions about their journeys to becoming practitioners, experiences of administering EFT to chronic disease patients, and general perceptions of EFT as a practice. Further questions emerged as the interviews progressed as per the semi-structured interview approach. Subsequently, the interviews were transcribed verbatim, including non-verbal responses such as laughter, long pauses/hesitation, and other emotional reactions as these can assist in the interpretative process (31).

### ***Data analysis***

The IPA data analysis process as described by Smith et al. (2009) was employed for this study (31). A brief overview of the data analysis process is outlined as follows:

- (1) Revisiting the data: This included review of interview notes, listening to an interview recording, and reading of an interview transcript.
- (2) Initial note-taking to capture points of interest: This was an iterative and non-exhaustive process that involved making detailed comments and notes on the data at hand, and engaging with the data both broadly and in-depth. Commentary was undertaken on the similarities and differences, extensions and inconsistencies in the participants' accounts.
- (3) Synthesising preliminary themes by reviewing exploratory notes: This step involved review of the exploratory notes from the previous step to rearrange and restructure the data into smaller manageable pieces and subsequently, 'themes'.

- (4) Grouping and organising emerging themes to structure data: Themes were organised based on their similarities, differences and contextual settings. This step was underpinned by the research question and scope.
- (5) Reviewing the next case: Once the above steps were completed for a given piece of data, the researcher moved to the subsequent piece of data (e.g. another participant's interview transcript) and repeated steps 1 – 4. In line with IPA's idiographic focus, each case was reviewed such that new themes could emerge in the current analysis, without being influenced by previous analyses.
- (6) Looking for patterns across cases: Once all the interview transcripts had been analysed using steps 1 - 4, connections were identified between the various cases, and their themes. Finally, the themes were restructured and renamed to introduce consistency in the terminology of the super and sub themes.

The aforementioned data analysis process was undertaken by the first author. The interview transcripts, analytical procedures, and findings were also discussed with the second and third authors, both of whom have extensive expertise in qualitative research methods. Additionally, a data analysis 'workshop' was undertaken with the second and third co-authors to further enhance the interpretative rigour of the data analysis process, and synthesise the emergent themes.

Brocki and Wearden (2006) highlight the importance of employing reflexive procedures in IPA (34). To ensure high quality in the execution of research, consideration of personal known and emergent conceptions, and emotional responses to the data is important (34). Therefore, the first author undertook reflexive note-taking throughout the research process. The first author's responses to the data, both emotional and analytical, were also extensively discussed with the co-authors throughout the research process, from

designing the research scope and methodology, and data collection, to data analysis and writing up of findings.

Member checking is often adopted as a means to ensure validity in certain qualitative traditions. The current study used the IPA research methodology and was grounded in an interpretive paradigm. Within this paradigm, unlike realist or essentialist paradigms, reality is considered to be multiple and constructed (42). The focus in an interpretive paradigm is not to discover a single, tangible reality, rather to construct an understanding of a contextual reality (42). Sandelowski (1993) argues that tools such as member-checking to reach a singular, repeatable response from participants, in fact, poses threat to validity in phenomenological research (42). Therefore, for the purpose of the current study, member verification was limited to the participants' demographic data and professional qualifications/certifications related information. This verification was conducted via email upon the completion of the interviews.

## **Results**

Results focus on EFT practitioners' perceptions and experiences of the application of EFT for supporting chronic disease healthcare. In describing their use of EFT with chronic disease patients, practitioners very often recounted their understanding of their clients' experiences before, during, and after therapy. While these professionals' accounts of their clients' experiences offer value, they cannot be equated with the patients' direct experiences. Practitioners' understanding of their clients' experiences, however, can provide further insight into the practitioners' worlds and how they use EFT to support chronic disease patients. Two super-ordinate themes are presented in this article, which explore practitioners' experiences of applying EFT to emotional and physical health issues respectively.

### *One technique, many emotions*

Participants indicated that a chronic disease patient requires support for addressing various different kinds of emotional issues, associated with their distant past (e.g. longstanding unresolved emotions related to past traumas), current situation (e.g. difficulty in coping with disease), as well as future. For example:

EFT can be used for just random things, and *anything*. So, there are so many creative ways to use EFT. So, on all the emotions around the dis-ease, or the disorder or the pain, plus using it for the symptoms ... the pain, plus using it for fear about the future. And, using it for major trauma. (Samantha)

Samantha's enunciation of the word 'disease' as two words, 'dis' and 'ease', is interesting, and represents disease as a lack of ('dis') 'ease' in the patient's life, which may, in turn, cause emotional distress. Samantha's quote provides some examples of emotional issues that a chronic disease patient might face, namely major trauma (from the past), emotions surrounding the health condition (in the present), and fears (about the future). Practitioners' use of EFT for helping their clients deal with emotional issues related to their past, present, and future are presented in this theme.

Participants suggested that harmful emotional and behavioural patterns exhibited in the present, which may be negatively impacting patients' health, may sometimes have their origins in difficult childhood experiences. Participants discussed their use of EFT for resolution of these longstanding emotional issues:

In the course of treatment, it usually emerges that a person has some limiting beliefs or behaviour patterns or emotional response patterns [e.g. addictive responses to food] that are... harming them. And so, I'll use EFT on, for example, feelings of low self-worth, difficulties in, in standing up for themselves. And so we start using EFT on that and then it often emerges that you know, [for example] their parents were... very over controlling and they weren't allowed to make decisions for themselves and

then we end up, working on their relationship with their parents ... It almost always ends up going a lot deeper ... and penetrating into their earlier childhood experiences. (Rachel)

Participants also discussed their use of EFT for dealing with unresolved emotions associated with major trauma. Frank discussed a particularly disturbing case, where he helped his client deal with emotions surrounding a physically and emotionally traumatising event:

A girl I worked with, she had ... incredibly painful kidneys ... We ended up doing some really deep emotional clearing of like, past trauma of sexual abuse ... I reckon through, her family members ... basically by her dad and his friends that were drunk. So it was like really, really really, like horrible. (Frank)

Participants suggested that sometimes patients may be under extreme distress, and delving into deep emotional issues from the past, such as those described above, may be overwhelming, even invasive. Therefore, practitioners discussed ways in which they may 'ease' their clients into the EFT process, by helping clients deal with surface-level issues that may be troubling them in their present situations. One particular case stood out for EFT practitioner, Taylor:

There was one client I worked with, who had back pain. She was really quite debilitated. She was a mother of three young children. She had been off work for about 12 – 14 months when I started working with her. And so, there were a lot of complicated emotions about guilt, not being a good mother, not providing for the household... lot of high expectations about what was achievable in a 24 hour day, in terms of just laundry, and school trips and all of that kind of stuff. So, the starting point was just kind of like, soft EFT, where we were not really doing full on tapping, because she was really sensitised. So, doing that, she felt would have been too much stimulation. So, we just [started] tapping across the collarbone points and "Even

though, I am struggling, I am okay” ... So, in the beginning, it was just “even though I am having this experience, and I am in this amount of pain, ‘failing as a mother’, ‘failing as an employee’, I am alright”, was a significant step in managing the pain, bringing down the intensity just a little bit, may be from a 9 to a 7. So, we did that for a good few weeks, until she was more stable .... So that was quite liberating for her, and she responded quite well to that. (Taylor)

A chronic disease can hamper people’s abilities to undertake day to day tasks, which may previously have been considered ordinary or taken for granted (Walker, 2010). Taylor uses EFT to assist this client come to terms with the most pressing issues at hand, such as inability to fulfil her roles as a parent, or an employee. It is also apparent from Taylor’s quote that therapeutic change may be a slow and incremental process that requires persistence.

Further to Taylor’s account, participants also stressed the importance of encouraging a sense of acceptance in patients, surrounding their illness. Samantha recounted an experience with a particular young client, who had recently been diagnosed with rheumatoid arthritis:

She was quite shocked. So, we had to deal with the shock of it, what does it mean, or the meanings or the beliefs around it... "I am only in my twenties" and "people don't get this when they are this age". So, yeah, we worked on all the surrounding beliefs and aspects and emotions to do with having rheumatoid arthritis, and we even did just a few rounds of... you know just saying the words "rheumatoid arthritis", "I have it", "I have it", you know, then there would be a shift, a cognitive shift, into "yeah, I have it", you know, "now what can we do about it?" (Samantha)

Samantha’s quote highlights the importance of ‘acceptance’ of the situation, as a precursor to an empowered state of problem-solving.

Another practitioner, Abigail, explained her use of EFT for dealing with the trauma surrounding the specific moment where a patient's diagnosis is revealed to him/her. For example:

We do a lot of tapping around the diagnosis - how it was revealed, where it was revealed, were they on their own. And with this particular client, [sharing story of client experiencing cancer relapse] she was in the car on her cell phone. She had had some tests, back and forth to her doctor. Her doctor and her specialist had all got involved, and were saying "don't worry"; and then sadly the results came back and there were obviously problems. So, she was called, and she happened to be in the car. So, we started with that and what it meant to be the mother of a very young teenager. Her daughter was 12 at the time. "What does it mean that it has returned? What does it mean about *you* that it has returned? *Why you?*" And of course thoughts for her around "did I not look after myself? Did I not learn anything the first time? Why me?" and all that. So, all those things were addressed. (Abigail)

Abigail appears to be interested in the specific details of the moments where diagnoses are revealed to her clients. It appears that she facilitates re-visitation of the memories of those traumatic events, by eliciting visual details such as being in a car, and receiving a phone call, which she then attempts to deal with, using EFT. She also points to the application of EFT for addressing the client's meanings of what it means to be ill, including perceptions of self, as illustrated by the client's reported self-blame around not learning anything from the previous cancer experience, and not looking after herself better.

Chronic disease patients may often suffer from a lack of optimism about their potential for health improvement. Abigail discussed the case of a client experiencing Crohn's disease to highlight this:

A lot of the work that we ended up doing was [on] the fear, as with many of my clients, that she would never recover ... the fear that her body would just never be well enough to be healed. Because she, used the expression, “waiting for the shoe to drop”. So, every time she made a breakthrough and recovered a little more, she was waiting for the other shoe to drop and for there to be a flare up. Or, for her energy levels to crash or whatever it was. (Abigail)

Abigail’s quote alludes to the non-linear nature of the journey to recovery from chronic disease. Such a spiral path to recovery, where minor improvements may sometimes be followed by the surfacing of other problems could instil feelings of fear in patients about the future and potential for recovery. Therefore, Abigail indicates that dealing with these fearful emotions formed a major part of her work with this particular client.

### ***Tapping on the physical***

The previous super-ordinate theme presented various emotional applications of EFT. Participants also discussed their use of EFT for dealing with physical issues. Participants illustrated their use of EFT to address physical issues, in two ways, firstly, by dealing with the emotions surrounding a physical symptom and secondly, by directly addressing, or, ‘tapping on’ the physical symptom.

EFT Practitioner, Rachel described her use of EFT for helping clients cope better with physical symptoms, by elevating their emotional state:

For symptom management, it’s common experience and it has been verified by research that our perception of pain is altered by our emotional state. So something hurts more if you feel sad, or lonely or unloved. People can manage pain and discomfort better when they feel, when they don’t have those negative emotional experiences. So just empowering people with this technique that can relieve, even quite intense physical pain and discomfort. Again... bearing in mind that... if there is a medical reason for the pain then it should be treated appropriately, but sometimes

there are types of pain that don't have no clear organic cause or that do have an organic cause and it's not really treatable. For example, chronic lower back pain, and people may not want to and it's probably inadvisable for them to be using really serious heavy duty pain medication on a daily basis. So they can be using tapping to decrease their perception of pain and increase their ability to carry out their normal tasks of living in their daily lives, then I think that's wonderful and that should be encouraged. (Rachel)

Rachel's quote above highlights an important juncture between emotional and physical well-being, and that perception of physical symptoms may be altered through a positive emotional state.

Practitioners also illustrated the application of EFT for alleviating physical symptoms purely through engaging the physical body. Participants suggested that the EFT process may be directly applied to physical issues, such as symptoms, without delving into any obvious emotional implications. One practitioner, Madeleine, discussed a particularly interesting case of a client who had suffered a stroke:

His arm was completely dead, and one side of him was dead. He couldn't pick a pen, he couldn't pick pieces of paper ... What he said to me was he just wanted to pick his new granddaughter up. We tapped on very very minute details about his fingers in that position. And as we were doing it, he mentioned that the doctor told him he would never ever get any better than this. So, I remember tapping, "even though this is what the doctor told me that I will never be able to....", and I remember I had to tap with my fingers [on him]. He started picking up things... a pen, a fork and a paper ... We worked in extreme detail, on the whole thing... "My arm remembers, my hand remembers, and my cells in my arm remember how to do this." ... Anyway... we thought, "Well let's check this out!" So, we went into the kitchen, we took out a knife, and a fork, he held it... Got a pen. But then, he said "I can't write anything easily". So, we worked on that issue of writing. So, he managed to write a few words. So, that was only about... an hour ... Next I said, "could I have permission to bring you back, see how you are?" ... I went back, and ... he was picking up his mobile... Later, he sent an email, and he'd actually been tapping himself, and his leg, which I

didn't realise at that time, because it was a short session, his leg was improving as well ... And, it was a bit surreal, because it all happened so quickly. (Madeleine)

Madeleine's quote is an interesting illustration of the engagement of the physical body in the tapping process. She appears to adopt a methodical approach with the intention of helping her client undertake specific tasks incrementally, such as lifting cutlery, writing, and lifting a mobile phone. Without appearing to investigate emotional issues, she guides her client to engage with his physical body, as illustrated by her expression of tapping on the 'very minute details' of the client's fingers in a specific position. Additionally, Madeleine appears to facilitate, through the use of affirmative statements such as 'my arm remembers', a positive expectation of recovery in her client.

Various other practitioners also noted that EFT may be used for symptomatic relief. For example:

I am working with a woman who had a skin condition, it is called Hailey Hailey, and it is a very painful skin condition. It was kind of secondary. I am working mostly on her ME [Myalgic encephalomyelitis] and fibromyalgia but the Hailey Hailey is obviously a big part of what affects her, because it is so... the skin really blisters, particularly, like in the groin, or under the arms, and these are really painful places and it cracks open. So, it is a very difficult experience ... So we work with it just on a symptom level and so it is manageable, but not solved. (Taylor)

Some practitioners further noted that certain medical treatments can cause pain and physical discomfort in patients. Participants discussed their use of EFT to alleviate physical symptoms associated with treatments:

She was having chemotherapy when I, started working with her ... She continued to have chemotherapy and we worked between those sessions. That affected the sessions quite a lot because, a lot of the time she was utterly exhausted, she was

nauseous, very distressed. So, a lot of our sessions were on those symptoms and tapping on those. (Abigail)

Another practitioner, Donna, who offers EFT treatment to children with cancer, also highlighted the same application:

I have children as young as two and three and four, they do tapping on their own ... A child before he has a spinal tap, he 'taps'. His parents go, "why are you doing this?", and he goes, "because it hurts less". A child doesn't need to understand it. He just knows that it hurts less, so he taps before and after, because then after whatever ache is still there, it goes away, you know, and he taps when he gets itching from a particular medication, that causes itching for him, and I asked him one day, I said, "well what happens?", and he goes, "oh, the itching goes away." He is four, he doesn't know how to explain it. He doesn't know why, he just knows it works. And, so if you have these issues, and you have a tool, young or old, a child, up to a child of a 100, or more, doesn't matter. (Donna)

Donna's quote powerfully illustrates that EFT may be applied to physical symptoms without any understanding of the underlying mechanism of action, or therapeutic expertise, and that age may not be a barrier in the application of the technique.

### **Discussion of Findings**

This is the first study to qualitatively explore EFT practitioners' experiences and perceptions of using EFT to support physical chronic disease patients. Two primary themes were presented in this article, namely, 'one technique, many emotions' and 'tapping on the physical'.

The first theme illustrated practitioners' experiences and perceptions of administering EFT for resolution of emotional issues related to patients' past, present and

future. Practitioners highlighted their use of EFT for dealing with longstanding emotional response patterns, limiting beliefs and behaviour patterns which often have their origins in childhood. Some psychological theories, such as Psychodynamics, suggest that unmet emotional needs during childhood as a result of difficult experiences (e.g. suboptimal parent-child relationships/interactions, adverse life events, such as sexual abuse, loss of a close elder/parent) may result in unproductive and unhealthful emotional, cognitive, or behavioural patterns, referred to as 'early maladaptive schemas' (43). The person may repeat these self-defeating patterns unconsciously throughout his/her life, unless those 'schemas' are brought to light through therapy or reflection. Maladaptive schemas often manifest in unhealthy patterns during adulthood, e.g. addictions, health problems or other mental health issues (43). Practitioner participants' accounts highlighted the use of EFT for bringing such maladaptive schemas to light and attempting to resolve deep-seated emotional issues.

Practitioners also discussed the use of EFT to help their patients accept their diagnoses, and cope with reduced ability to undertake daily tasks, and fulfil their societal and economic roles, when suffering from chronic diseases. Stanton, Revenson and Tennen (2007) argue that chronic diseases have crucial social and psychological implications which necessitate considerable psychological adjustment (44). Indeed 'acceptance' is the precursor to adjustment (45). McCracken, Caron, Eccleston et al. (2004) concur that acceptance can offer patients 'choice' in the moment of pain or distress, where previously there may have been avoidance or denial of the situation leading to a false and unproductive sense of control (46). Acceptance can also help people to make better decisions driven by their visions of their desired health outcomes, rather than by unhelpful fear-based emotions (46). Brattberg (2008) indicates that EFT relies on

the premise that acceptance of, rather than resistance to a particular circumstance or condition, can reduce suffering (24).

Participants illustrated their use of EFT for addressing patients' meanings and perceptions of themselves, and their illnesses. Scharloo, Kaptein, Weinman et al. (1998) suggest that patients' perceptions such as cause of illness (including self-blame), beliefs regarding the curability and manageability of the illness, and beliefs and perceptions about the disease's consequences can all have impacts on a patient's health-related behaviour, and ultimately, on the patient's physical health and well-being (47).

Practitioners highlighted their use of EFT for alleviating fears about the future in their patients, as the patients went through a spiral path to well-being improvement and recovery. Whitley and Drake (2010) propose, in the context of mental health, that recovery is a multi-faceted concept. One of the facets of recovery is 'existential recovery' which includes an improved sense of hope and locus of control of illness, as opposed to feelings of hopelessness about the future, and feeling controlled by the illness (6). Practitioners' use of EFT for promoting hope for improved well-being may also be viewed from the school of thought of 'Positive Psychology'. For example, investigations by Taylor, Kemeny, Reed et al. (2000) found that even unrealistically positive expectations about the future were health protective for not only mental health, but also physical health (e.g. slower disease progression) in HIV positive men (48).

The second theme discussed in this article related to the application of EFT on physical symptoms. Literature on this theme is scarce. Most literature discusses therapeutic interventions for physical conditions, primarily in the context of medically unexplained symptoms, and psychosomatic disorders. In interpreting the participants' use of EFT on physical symptoms, one may, thus, consider proposed mechanisms of therapeutic action in EFT (as discussed in the 'Introduction' section), such as stress

hormone regulation, soothing of the threat ‘fight, flight, freeze’ response in the amygdala leading to an improved emotional state. The study’s participants had discussed their use of EFT for pain perception, and how negative emotions may increase the perceived intensity and limiting impacts of physical pain. Heinrich, Monstadt and Michel (2009) discuss provision of psychological therapy for chronic back pain, based on a biopsychosocial model of pain. Heinrich et al. (2009, p. 937) suggest that ‘pain-eliciting and pain-aggravating thoughts’ impact illness behaviour (49). In addition, Heinrich et al. (2009) highlight the importance of monitoring maladaptive thoughts, feelings, and behaviour to improve coping abilities with physical symptoms (49).

Additionally, participants’ accounts allude to EFT as a complementary modality to support biomedical healthcare. Biomedical treatments of some diseases, such as chemotherapy for cancer treatment, can have adverse side-effects (e.g. pain, nausea). Participants of this study indicated their use of EFT for alleviating symptoms arising from biomedical interventions (e.g. medicinal and treatment side-effects). Redd, Montgomery and Duhamel (2001) also argue that behavioural interventions can be useful for alleviating side-effects of invasive biomedical treatments, such as anticipatory nausea, vomiting, anxiety, and pain (50).

### ***Implications for practice***

Participants illustrate their use of EFT on both emotional and physical issues to support chronic disease patients. Overall, the aforementioned themes presented in this study, namely ‘one technique, many emotions’, and ‘tapping on the physical’ demonstrate a patient-centred healthcare approach, underpinned by the biopsychosocial model of health. A patient-centred healthcare approach is one that goes beyond medical treatment, to an ‘integrated understanding of the patients’ world – that is their whole person, emotional needs and life issues’ (51, p. 445). Practitioners’ approach to their use of EFT appears to

take into account patients' individual needs and circumstances (such as unique personal history, life circumstances and emotions surrounding those situations). Participants' accounts indicate that chronic disease patients may benefit from a more holistic healthcare program that takes into account, not only the biomedical dimension, but also the psychological and social dimensions. EFT offers potential as a technique that may be used by health practitioners to support the psychosocial aspect of chronic disease healthcare.

### ***Limitations of Study***

EFT practitioners may have a bias towards EFT. They are likely to have personal belief in the technique, given that offering this therapy forms their vocation. As such, there may be a tendency to over-estimate the benefits of EFT. Additionally, practitioners' accounts of their clients' experiences must not be equated with the clients' direct experiences. Secondly, the study's participants are based in many different countries. Different countries have different public health care systems and arrangements for their citizens, which could influence the experiences of the study's participants with their respective clients. Thirdly, this study took all types of physical chronic health conditions under consideration. Given that chronic diseases vary so widely in their causes, symptoms, and treatments, the findings of this study may be interpreted in the context of generalised patient well-being only, and not disease-specific healthcare.

### **Conclusion**

Chronic disease patients may benefit from a holistic healthcare approach that adopts a patient-centred view to illness management and treatment. The present study provides a

useful first step towards understanding users' experiences of EFT for supporting chronic disease healthcare. EFT may be administered to chronic disease patients, for addressing emotional issues surrounding a disease, as well as for supporting management of physical symptoms.

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### **Conflicts of Interest**

None to declare.

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Table 1. Participant Information.

<b>Participant pseudonym</b>	<b>Age</b>	<b>Country of Residence</b>	<b>Gender</b>	<b>Years of Professional EFT Experience</b>	<b>Professional Status</b>	<b>Examples of chronic illnesses dealt with in practice</b>
Abigail	43	Canada	Female	12 years	- AAMET Accredited EFT Practitioner - AAMET Accredited EFT Trainer - Canada AAMET Representative	CFS, Fibromyalgia, Arthritis, Multiple Sclerosis, Crohn's Disease, Ulcerative Colitis, Irritable Bowel Syndrome, Diabetes, Lou Gehrig's (ALS)
Donna	55	Mexico	Female	12 years	- AAMET trained EFT Practitioner - AHEFT certified EFT Trainer (Spanish association for EFT trainers)	Fibromyalgia, Gastritis, Colitis, Frozen Shoulder, Sciatic Nerve Pain, Chronic Pain, High Blood Pressure, Cancer, Diabetes
Frank	26	Australia	Male	4 years	- AAMET trained EFT Practitioner	Lyme's Disease, Vaginal Infection, Chronic Pain
Iris	33	England	Female	8 years	- AAMET Accredited EFT Practitioner - AAMET Accredited EFT Trainer - AAMET Accredited EFT Supervisor	CFS, Fibromyalgia, Multiple Chemical Sensitivity

<b>Participant pseudonym</b>	<b>Age</b>	<b>Country of Residence</b>	<b>Gender</b>	<b>Years of Professional EFT Experience</b>	<b>Professional Status</b>	<b>Examples of chronic illnesses dealt with in practice</b>
Madeleine	62	Spain	Female	12 years	- AAMET Accredited EFT Practitioner - AAMET Accredited Trainer of Trainers - AAMET Accredited EFT supervisor	Multiple Sclerosis, Cancer, Chronic Pain
Rachel	43	Australia	Female	10 years	AAMET trained EFT Practitioner	CFS, Migraines, Chronic Pain, Rheumatoid Arthritis, Ulcerative Colitis, Diabetes
Samantha	47	Australia	Female	9 years	- AAMET Accredited EFT Practitioner - AAMET Accredited EFT Trainer	Chronic Pain, Cancer, Arthritis
Taylor	44	England	Non-binary	6 years	AAMET Accredited EFT Practitioner	Fibromyalgia, CFS, Hailey Hailey, Chronic Pain, Irritable Bowel Syndrome