

Original Article



Borrowing Benefits: Group Treatment With Clinical Emotional Freedom Techniques Is Associated With Simultaneous Reductions in Posttraumatic Stress Disorder, Anxiety, and Depression Symptoms

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Abstract

Clinical Emotional Freedom Techniques (EFT) is an evidence-based treatment for depression and anxiety. The current study sought to elucidate the relationship between posttraumatic stress disorder (PTSD), depression, and anxiety in a nonclinical population. The sample (N = 81) comprised participants at five 2-day EFT workshops. All groups used an EFT protocol called Borrowing Benefits, in which the group facilitator works with a single client while other participants self-apply EFT. Participants were assessed on 9 specific conditions as well as on the breadth (Positive Symptom Total [PST]) and depth (General Symptom Index [GSI]) of psychological distress. Physical pain and addictive cravings were also assessed. Significant reductions were observed in all measures ($P < .03$). Associations between PST, GSI, and PTSD were significant ($P < .026$). Participants maintained all gains at 6-month follow-up ($P < .02$) with the exception of the Hostility subscale, while Cohen's $d = 0.54$ indicated a moderate treatment effect for PTSD. The relationship between psychological and physiological conditions identified in this study is consistent with that found in other studies. Group treatment is cost-effective and efficient, and the efficacy of EFT in groups indicates the utility of the Borrowing Benefits technique.

Keywords

anxiety, depression, posttraumatic stress disorder (PTSD)

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Clinical Emotional Freedom Techniques (EFT) is an evidence-based method for the treatment of anxiety, depression, and posttraumatic stress disorder (PTSD).¹ Meta-analyses of randomized controlled trials (RCTs) have found “large” treatment effects for these three conditions.²⁻⁴ EFT is a simple self-help method that combines acupressure with elements drawn from cognitive and exposure therapies.⁵ It is described in *The EFT*

Manual, a treatment manual that has been available from the inception of the method.^{6,7} The term “Clinical EFT” refers to the manualized form of the method as validated in more than 100 studies (Research.EFTuniverse.com). Investigation of the physiological effects of Clinical EFT finds that it is associated with the regulation of cortisol, with beneficial changes in gene expression, and with regulation of autonomic nervous system activity.^{1,8,9}

A typical EFT session begins with the identification of the presenting issue, for example, “depression.” Similar to other therapies, the Clinical EFT practitioner then probes for childhood events that might have contributed to the issue, for example,

My father was in the army and we moved a lot as he was transferred to different bases. I was in a new school every six months, and I was the “new boy” and usually taunted. I was a magnet for the bullies.

The practitioner then identifies “the worst or the first” event (eg, “Sean Casey hit me so hard he broke my tooth.”) and obtains a rating from the client on the severity of emotional triggering on 0 to 10 Likert-type scale.

The client then stimulates 7 acupressure points using fingertip tapping while focusing mentally on the event. A second 0 to 10 score is then obtained. The client’s level of emotional distress is usually rapidly attenuated. Once it reaches zero, EFT is used on a second issue. If repeated applications of EFT do not reduce the client’s scores, eye movements similar to those used in eye movement desensitization and reprocessing (EMDR) and an additional 5 acupressure points are added to the procedure.⁷

The protocol for working with groups is called Borrowing Benefits and is described in the manual. The group facilitator works with an individual in front of the group, while other members self-apply EFT. The first study to use Borrowing Benefits examined its use in 5 groups of health care professionals totaling 216 participants.¹⁰ It found significant reductions in anxiety, depression, and other psychological conditions. A replication of this study observed similar results.¹¹

Simultaneous research resulted in the publication of a number of studies of EFT for PTSD. A study of Borrowing Benefits in 218 veterans and their spouses found significant reductions in PTSD symptoms.¹² An examination of anxiety and depression in veterans successfully treated for PTSD found concurrent reductions in symptoms.¹³ Similar results were found in a nonclinical sample of veterans at risk for PTSD.¹⁴

The current study sought to extend the earlier Borrowing Benefits research cited above by elucidating the relationship between PTSD and other psychological conditions such as anxiety and depression. It used the same design as the earlier studies of Borrowing Benefits but combined an assessment of 9 conditions such as anxiety and depression with a PTSD evaluation, the PTSD Checklist, in order to explicitly measure the associations between comorbid conditions.

Method

Participants were a convenience sample (N = 81) attending one of five 2-day EFT workshops. Two of these were in the United Kingdom, while three were in the United

States. They were assessed before, after, and 6 months after the workshop. All subjects provided informed consent. EFT was delivered with fidelity to *The EFT Manual*.⁷

Psychological symptoms were assessed using the Symptom Assessment 45 (SA-45).^{15,16} It has 2 general scales, the General Symptom Index (GSI) that measures the depth of symptoms, and the Positive Symptom Total (PST) that measures the breadth. Nine subscales measure psychological conditions such as anxiety and depression. Insomnia was assessed using the Insomnia Severity Index.¹⁷ PTSD was measured using the PTSD Symptom Checklist (PCL).¹⁸ Pain was assessed using the Pain Rating Scale.¹⁹ The emotional intensity of a single traumatic childhood memory was assessed on an 11-point Likert-type scale ranging from 0 to 10.²⁰ Changes in cravings for substances such as chocolate and alcohol were assessed on a similar scale. Insomnia, pain, emotional intensity, and cravings were not assessed on follow-up.

Participant safety was supported by the presence of trained practitioners experienced in treating PTSD. A 1:10 ratio of practitioners to participants was maintained. The investigators have published extensive research on PTSD as well as other mental health disorders and the workshops were conducted to minimize the possibility of abreactions. No adverse events were noted.

Results

There were 81 participants who completed the pretest and posttest SA-45s. Either pre- or posttest were unavailable for 16 participants. Of those who had complete pre-post data, 49 completed the 6-month follow-up.

Statistical tests were performed to compare participants with and without follow-up data. The mean age was 54.3 years ($n = 49$) for those with follow-up data and 50.1 years ($n = 32$) for those without. The difference was not significant ($P = .081$). Female participants comprised 84% of those with follow-up data and 72% of those without, again with no significant difference ($\chi^2 = 1.62, P = .202$).

A 2-factor repeated-measures analysis of variance (ANOVA) with Time (Pretest and Posttest) and Gender effects was performed on each variable to see if there were any interactions with Gender. No significant interactions were found so Gender was removed from consideration and an ANOVA with the Time effect for each variable was performed. The resulting F -statistic and P -value for the Time effect of each variable is provided in Table 1. Statistically significant ($P < .05$) Time effects were found for all variables.

Table 1. Pretest and Posttest Means (Standard Deviation), *F* and *P* (*N* = 81).

Variable	Pretest	Posttest	<i>F</i>	<i>P</i>
Anxiety	58.0 (8.3)	52.7 (8.3)	58.89	<.001
Depression	55.5 (7.3)	52.5 (7.3)	23.63	<.001
Obsessive-compulsive disorder	57.6 (9.3)	53.0 (9.3)	39.79	<.001
Phobic anxiety	60.6 (4.1)	52.8 (7.6)	83.48	<.001
Somatization	57.3 (9.5)	59.5 (3.3)	4.79	.032
Hostility	57.5 (5.7)	56.4 (4.7)	9.09	.003
Interpersonal sensitivity	55.6 (7.4)	53.4 (6.3)	14.75	<.001
Paranoid ideation	54.1 (7.4)	51.2 (6.6)	24.59	<.001
Psychoticism	61.2 (4.0)	60.1 (3.3)	12.05	<.001
General Symptom Index	55.3 (9.2)	49.3 (9.9)	60.55	<.001
Positive Symptom Total	55.1 (9.4)	49.5 (11.1)	11.59	<.001
Posttraumatic stress disorder (n = 79)	29.9 (11.9)	25.4 (10.4)	30.82	<.001
Insomnia (n = 59)	5.2 (4.9)	3.8 (4.2)	21.74	<.001
Pain (n = 58)	4.9 (2.1)	1.9 (2.1)	129.26	<.001
Emotion (n = 57)	6.9 (2.4)	2.6 (2.2)	222.91	<.001
Craving (n = 58)	6.6 (2.5)	2.2 (2.4)	160.58	<.001

An ANOVA with the Time effect for each variable was performed on the SA-45 subscales, GSI, PST, and PCL to examine changes over time in the 49 subjects for whom follow-up data were available. The resulting *F*-statistic and *p*-value for the Time effect of each variable is provided in Table 2. A statistically significant ($P < .05$) Time effect was found for all variables except Hostility.

Table 2. Pretest, Posttest, and Follow-up Means (Standard Deviation), *F* and *P* (*n* = 49).

Variable	Pretest	Posttest	Follow-up	<i>F</i>	<i>P</i>
Anxiety ^a	56.3 (7.9)	51.4 (7.7)	51.4 (7.2)	21.09	<.001
Depression ^a	55.0 (6.5)	52.0 (7.0)	51.2 (5.4)	13.17	<.001
Obsessive-compulsive disorder ^a	56.7 (9.7)	52.2 (9.3)	52.2 (8.9)	16.09	<.001
Phobic anxiety ^a	60.1 (3.6)	52.1 (7.6)	51.6 (6.8)	54.99	<.001
Somatization ^b	55.4 (9.0)	59.0 (2.5)	59.0 (2.4)	8.31	<.001
Hostility	56.5 (4.3)	55.9 (3.9)	55.9 (3.9)	2.44	.092
Interpersonal sensitivity ^c	54.0 (7.3)	52.7 (5.9)	52.1 (5.2)	4.09	.020
Paranoid ideation ^a	53.2 (6.7)	50.6 (5.6)	50.2 (5.6)	16.29	<.001
Psychoticism ^a	60.9 (4.0)	59.6 (2.8)	59.7 (2.2)	6.89	.002
General Symptom Index ^a	53.7 (8.8)	48.2 (9.4)	47.7 (8.9)	24.39	<.001
Positive Symptom Total ^a	53.8 (9.5)	48.1 (10.4)	47.7 (10.3)	28.59	<.001
Posttraumatic stress disorder (<i>n</i> = 48) ^c	28.1 (11.2)	23.7 (8.6)	22.7 (8.6)	4.43	.014

^a Pretest > Posttest and 120 days.

^b Pretest < Posttest and 120 days.

^c Pretest > 120 days.

Post hoc Tukey tests showed a statistically significant decrease in both the posttest and follow-up scores relative to the pretest score for the 2 general scales, anxiety, depression, obsessive-compulsive disorder, phobic anxiety, paranoid ideation, psychoticism, GSI, and PST. Somatization showed a statistically significant increase in both the posttest and follow-up scores relative to the pretest score. Interpersonal sensitivity and PTSD showed only a statistically significant pretest score increase relative to the follow-up score. There were no differences in the 3 mean scores for hostility.

To test the relationship between reductions in PTSD and reductions in other psychological conditions, we compared GSI and PST with PCL scores. The correlations are presented in Table 3. Associations were found between symptomatology and PTSD, with scores of both declining significantly after treatment ($P < .026$) and on follow-up ($P < .012$). Cohen's difference was calculated in order to determine the size of the effect of

EFT treatment. A value of $d = 0.54$ was identified between pre- and follow-up for PTSD, indicating a moderate treatment effect.

Table 3. Correlations Between Posttraumatic Stress Disorder and Psychological Symptoms.

Correlation	<i>r</i>	<i>n</i>	<i>P</i>
Pre to post reduction in GSI vs PCL	.316	79	.005
Pre to post reduction in PST vs PCL	.251	79	.026
Pre to follow-up reduction in GSI vs PCL	.390	48	.006
Pre to follow-up reduction in PST vs PCL	.358	48	.012

Abbreviations: GSI, General Symptom Index; PCL, Posttraumatic Stress Disorder Symptom Checklist; PST, Positive Symptom Total.

Discussion

The design of the current study sought to extend earlier research on Borrowing Benefits that showed that group application of EFT was efficacious for treating psychological symptoms. It included a measure of PTSD. A significant association between PTSD and the breadth (PST) and depth (GSI) of psychological symptoms was found. Along with the body of literature already extant, it demonstrates that EFT is a robust and reliable method of producing improvements in general mental health. Like other studies in the field, the effects of EFT were lasting, with participant gains maintained on follow-up. This body of work points to the utility of therapeutic methods that reduce a spectrum of mental health issues simultaneously, rather than focusing on narrow diagnostic categories. The study also included physiological measures of pain, insomnia, and cravings. Reduction in these symptoms was associated with improvements in mental health.

Group therapy is both efficient and cost-effective. When successful therapies are offered in group format, the impact of the presence of trained professionals is multiplied when compared to one-on-one sessions. Borrowing Benefits has been used in many settings in which individual psychotherapy is impractical, such as in refugee camps, with earthquake survivors, after terrorist attacks, in school classrooms, with teams of athletes, in weight loss support groups, in war veteran retreats, and in hospital inpatient groups.⁷

In addition, a limited amount of training is required to implement Borrowing Benefits. Practitioners need not be licensed mental health practitioners, though when dealing with PTSD, participant safety is paramount. In several of the above settings, practitioners were life coaches or volunteers, and a randomized controlled trial comparing their efforts found that they were effective though not quite as effective as professionals.²¹

The study had a number of limitations. The population consisted of convenience samples of EFT workshop participants, and may be unrepresentative of other

demographic groups, especially patients with clinical symptom levels who are seeking treatment. There was no control group; the study simply measured the difference in symptoms between the start and end of the workshop, and a 6-month follow-up. Participant improvement might have been partially due to demand factors, therapist allegiance, or the non-specific effects of any therapy.

Despite these limitations, when taken together with the large body of research on EFT, the study demonstrates that participants in brief EFT workshops have a reasonable chance of experiencing improved mental health. These gains persist over time. A complex of comorbid psychological symptoms appears to be remediated by EFT, and both the breadth and depth of distress decline after treatment. Meta-analysis shows that outcome studies such as this one demonstrates convergent statistical validity with randomized controlled trials of EFT.²⁻⁴

Conclusion

We conclude that there is an important clinical relationship between PTSD and other psychological conditions. While precise diagnoses on the basis of *Diagnostic and Statistical Manual of Mental Disorders* criteria may be common clinical practice, clients often present with comorbid conditions. A simple evidence-based self-help technique like EFT is an appropriate primary choice to treat this complex of co-occurring symptoms. Improvements in mental health are associated with physical symptoms like pain, insomnia and cravings. This and similar studies demonstrate that group EFT treatment using the Borrowing Benefits protocol is efficient and cost-effective.

Authors' Note

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Author Contributions DC collected the data and wrote the article with the exception of the Results section. DH analyzed the data and wrote the Results section.

Declaration of Conflicting Interests

The authors declared the following potential conflicts of interest with respect to the research, authorship, and/or publication of this article: DC receives income from presentations and publications on the therapeutic approach described.

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