



**MONASH** University

# **Tapping into Recovery: Exploring Experiences of Emotional Freedom Techniques (EFT)**

*Mahima Kalla*

*B.E. Environmental Engineering (H1)*

A thesis submitted for the degree of *Doctor of Philosophy* at  
Monash University in (2017)  
School of Rural Health  
Faculty of Medicine, Nursing and Health Sciences

## Copyright notice

© Mahima Kalla (2017). Except as provided in the Copyright Act 1968, this thesis may not be reproduced in any form without the written permission of the author.

I certify that I have made all reasonable efforts to secure copyright permissions for third-party content included in this thesis and have not knowingly added copyright content to my work without the owner's permission.

To all people with a chronic illness:

*“Some days there won't be a song in your heart. Sing anyway.”*

-Emory Austin

## Abstract

This PhD study aimed to explore users' experiences of using a contemporary psychotherapeutic technique, Emotional Freedom Techniques (EFT) to support physical chronic disease healthcare. This study was underpinned by a biopsychosocial view of health, and a personhood approach to healthcare, which suggests that chronic disease patients may benefit from psychological support. Furthermore, EFT's delivery via telephone/online mediums, and self-administration of EFT by patients may have implications for the social dimension of health; for example, people facing geographical barriers to access of support services may be able to receive telephone-delivered EFT support. The research objectives that I set out to explore were:

- EFT practitioners' perceptions and experiences of using EFT to support chronic disease patients;
- chronic disease patients' personal symbolic meanings of their illnesses as emergent from their experience of EFT therapy;
- chronic disease patients' personal notions of recovery; and
- the usefulness of telephone/internet delivery and self-administration of EFT in the context of the World Health Organization (WHO) determinants of health.

A qualitative research orientation lends itself to the exploration of people's unique and subjective experiences. A constructivist epistemological position, assuming a symbolic interactionist theoretical perspective, was adopted for this study. Interpretative Phenomenological Analysis was chosen as the study methodology. Eight chronic disease patients and eight EFT practitioners were interviewed for this study. Four results chapters are presented in this thesis, each of which address one of the aforementioned research objectives. An overview of the emergent themes which are presented in each of the results chapters has been provided in Table a.

**Table a: Overview of Emergent Themes presented in Results Chapters**

Overarching theme / Results chapter	Themes presented
EFT as a practice for supporting chronic disease healthcare	<ul style="list-style-type: none"> <li>- One technique, many emotions</li> <li>- Tapping on the physical</li> </ul>
Patients' meanings of chronic disease	<ul style="list-style-type: none"> <li>- Disease as an embodiment of unresolved emotional issues</li> <li>- Disease as a call for 'time-out' and attention</li> <li>- Disease as a boundary from other people</li> </ul>
Patients' constructions of recovery	<p><u>Constructions of the Recovery Journey:</u></p> <ul style="list-style-type: none"> <li>- Opening up to the possibility of recovery</li> <li>- The Spiral Path to Recovery</li> <li>- Creating a new me</li> </ul> <p><u>Markers of Recovery:</u></p> <ul style="list-style-type: none"> <li>- Improved emotional state</li> <li>- No longer restricted by illness</li> <li>- Moving beyond survival</li> </ul>
Evaluation of EFT using WHO Determinants of Health	<ul style="list-style-type: none"> <li>- Experiences of online EFT therapy</li> <li>- Experiences of telephone delivery of EFT</li> <li>- Online communities of support</li> <li>- EFT for self-care</li> </ul>

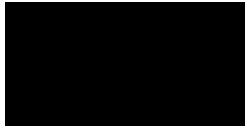
The study's emergent findings were synthesised into a healthcare model namely, 'Using EFT to support chronic disease healthcare for the patient as a whole-person'. This model which is underpinned by a person-centred view of healthcare, views the patient as a 'whole-person' situated within a social context/environment and having a unique life story, and circumstances.

Some of the study's limitations include a potential practitioner bias, socio-demographic diversity of the participant sample leading to reduced sample homogeneity, and lack of specificity of chronic illnesses under consideration. Further research may be conducted on users' experiences of EFT for specific chronic diseases, and/or for more defined participant samples (e.g. specific age-groups, gender, and places of residence). Researchers may also wish to explore my proposed model's applicability to other psychological interventions.

## Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Signature:



Print Name: **MAHIMA KALLA**

Date: **14 August 2017**

## **Publications during enrolment**

Kalla, M., Simmons, M., Robinson, A., & Stapleton, P. (2017). Emotional Freedom Techniques (EFT) as a practice for supporting chronic disease healthcare: A Practitioners' Perspective. *Disability and Rehabilitation*, Online First Publication. doi: 10.1080/09638288.2017.1306125.

Kalla, M., Simmons, M., Robinson, A., & Stapleton, P. (2017). Making sense of chronic illness using Emotional Freedom Techniques (EFT): An existential view of disease. *Disability and Rehabilitation*, under review.

Kalla, M. (2016). Supporting Chronic Disease Healthcare through Remote Emotional Freedom Techniques (EFT) Treatment and Self-care: An Evaluation Using the WHO Determinants of Health. *Energy Psychology: Theory, Research and Method*, 8(1), 55-66. doi: 10.9769/EPJ.2016.8.1.MK.



## **Thesis including published works declaration**

I hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes two original papers (Chapters 4 and 7) published in peer reviewed journals and one submitted publication (Chapter 5). The core theme of the thesis is users' experiences of Emotional Freedom Techniques (EFT) for supporting chronic disease healthcare; this includes experiences of both patients who have used EFT to assist their own healthcare regimes, as well as EFT practitioners, who have administered EFT to support chronic disease patients.

The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the student, working within the School of Rural Health under the supervision of Dr Margaret Simmons, Dr Anske Robinson, and Dr Peta Stapleton (external). In the case of Chapters 4 and 5, my contribution to the work has been outlined in the Table b.

I have not renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.

**Table b: Overview of published works included in the thesis**

Thesis Chapter	Publication Title	Status (published, in press, accepted or returned for revision, submitted)	Nature and % of student contribution	Co-author name(s) Nature and % of Co-author's contribution*	Co-author(s), Monash student Y/N*
<b>Chapter 4</b>	Emotional Freedom Techniques (EFT) as a practice for supporting chronic disease healthcare: A Practitioners' Perspective ( <i>Journal: Disability &amp; Rehabilitation</i> )	Published	80% - Concept development, key ideas, development, and writing up	Dr Margaret Simmons, Dr Anske Robinson, Dr Peta Stapleton – supervision, manuscript review and feedback (20%)	N
<b>Chapter 5</b>	Making sense of chronic illness using Emotional Freedom Techniques (EFT): An existential view of disease ( <i>Journal: Disability &amp; Rehabilitation</i> )	Under review	80% - Concept development, key ideas, development, and writing up	Dr Margaret Simmons, Dr Anske Robinson, Dr Peta Stapleton – supervision, manuscript review and feedback (20%)	N
<b>Chapter 7</b>	Supporting Chronic Disease Healthcare through Remote Emotional Freedom Techniques (EFT) Treatment and Self-care: An Evaluation Using the WHO Determinants of Health  ( <i>Journal: Theory, Research &amp; Treatment</i> )	Published	100% - Concept development, key ideas, development, and writing up	N/A	N/A

**Student signature:**



**Date:** 14 August 2017

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the student's and co-authors' contributions to this work. In instances where I am not the responsible author I have consulted with the responsible author to agree on the respective contributions of the authors.

**Main Supervisor signature:**



**Date:** 14 August 2017

## Acknowledgements

This thesis would not have been possible without the sixteen participants (EFT practitioners, and people with chronic illnesses) who generously donated their time towards this research. Your stories have inspired me; you have made me laugh, made me cry and filled me with hope. My resolve to tell your stories to the best of my ability has been at the centre of this study. Thank you.

I thank my supervisors, Dr Margaret Simmons, Dr Anske Robinson and Dr Peta Stapleton. Dr Margaret Simmons has enriched not only this study, but also my research and academic career with her sound guidance, widespread knowledge of literature and qualitative methodologies, and kindness. Dr Anske Robinson has been there with me on this journey from the very beginning. This thesis would not have been possible without her unending support, both academic and moral. I thank Dr Peta Stapleton, who has provided me invaluable subject-matter expertise throughout this thesis, and given me opportunities to collaborate with her on other research projects.

I also thank my former supervisors: Dr Hanan Khalil for her advice and support on conducting a systematic review of EFT literature which I presented at the *16<sup>th</sup> Annual Energy Psychology Conference 2014* (Phoenix, AZ); and Dr Eleanor Mitchell for her advice on quantitative research methodologies. I thank Dr Sonia Allen for her advice on phenomenological research and her kind words of encouragement, especially in the final days of my candidature.

I also thank the EFT community around the world for their tireless work and commitment to improving people's lives. I extend my gratitude to my family for being the wind beneath my wings. I thank my friends, particularly Dr Alexander De Foe and Dr Sue Barker for always taking the time to provide advice, encouragement, and support whenever I needed it. I thank my Shanti Mission Community, and my teacher in life, Shakti Durga.

Finally, I thank you, my readers. I hope that this work will enrich your life, the way it has mine. What started as a passing thought, a distant ‘what-if’, morphed into a research study that I could not have conceptualised when I first began, and amid many moments of joy, laughter, frustration, and exhilaration, has ultimately proved to be an immensely satisfying journey. In formally welcoming you to this work, I offer you the following quote:

*Before you examine the body of a patient,*

*Be patient to learn his story.*

*For once you learn his story,*

*You will also come to know*

*His body.*

- Suzy Kaseem (*The Maxims of Medicine*)

# Table of Contents

---

List of Tables and Figures.....	xviii
List of Abbreviations/Acronyms.....	xix
<b>Chapter 1: Introduction.....</b>	<b>1</b>
Setting the scene.....	1
Emotional Freedom Techniques: An Introduction.....	3
Chronic illness, EFT, and this study .....	6
Chapter Summary .....	7
<b>Chapter 2: Literature Review .....</b>	<b>9</b>
Mind-Body Interconnectedness: The Biopsychosocial Model.....	9
Person-centred Healthcare .....	12
Mind-body Co-Emergence of Disease .....	15
Beyond mind-body dualism: Personhood and Symbolic Disease .....	18
The Recovery Model .....	20
History of Emotional Freedom Techniques.....	25
Using EFT to support physical illness healthcare.....	27
The social aspect of healthcare: Determinants of Health .....	33
Genetics (Individual behaviours and coping).....	34
Health Services and Physical Environment.....	35
Social support.....	36
Gap analysis and direction for this study .....	36
Chapter Summary .....	38
<b>Chapter 3: Study Methodology .....</b>	<b>39</b>

Salient Features of Qualitative Research .....	39
Methodological Framework .....	41
Epistemological position: Constructivism.....	43
Constructivism in Psychotherapy and EFT.....	45
Exploration and resolution of early life issues.....	45
Construction of new meanings.....	47
Client as a change agent.....	47
Outlook towards emotions.....	48
Theoretical Stance: Symbolic Interactionism.....	49
Chosen Methodology: Interpretative Phenomenological Analysis.....	50
Phenomenology .....	52
Hermeneutics .....	56
Idiography.....	57
The Phenomenon .....	58
Positioning the researcher within the research.....	58
Insider Research.....	58
Reflexive Processes.....	59
Methods.....	61
Data Collection .....	61
Sampling and Recruitment .....	62
How the interviews were conducted.....	65
Participants .....	67
Member checking.....	67
Data Analysis.....	71
Chapter Summary .....	77

<b>Chapter 4: Emotional Freedom Techniques (EFT) as a practice for supporting chronic disease healthcare: A practitioners' perspective .....</b>	<b>78</b>
Introduction.....	78
Chapter Contents: Journal article .....	78
Chapter Summary .....	89
<b>Chapter 5: Making sense of chronic disease using Emotional Freedom Techniques (EFT): An existential view of illness .....</b>	<b>90</b>
Introduction.....	90
Chapter Contents: Journal article .....	91
Chapter Summary .....	128
<b>Chapter 6: Chronic disease patients' constructions of recovery.....</b>	<b>129</b>
Introduction.....	129
Constructions of the Recovery Journey.....	130
'Opening up' to the possibility of recovery.....	130
The 'Spiral Path' to recovery.....	134
Creating a new 'me' .....	135
'Markers of Recovery'.....	144
Improved Emotional State(s).....	145
No longer restricted by illness .....	147
Moving beyond survival.....	150
Discussion of themes .....	152
Chapter Summary .....	156
<b>Chapter 7: Supporting Chronic Disease Healthcare through Remote Emotional Freedom Techniques (EFT) Treatment and Self-care: An Evaluation using the WHO Determinants of Health.....</b>	<b>157</b>



Introduction.....	157
Chapter Contents: Journal article .....	158
Chapter Summary .....	171
<b>Chapter 8: Discussion .....</b>	<b>172</b>
Proposed Model: Using EFT to support chronic disease healthcare for the patient as a whole-person .....	175
Emotional health of the patient as a ‘whole-person’ .....	178
Past: Addressing past difficult experiences .....	179
Present: Dealing with the illness experience.....	180
Future: Moving towards Recovery.....	183
Physical health of the patient as a whole-person.....	185
Facilitating symptom management through psychological support.....	186
Changing relationship with the body.....	188
The social environment.....	190
Limitations of study.....	192
Recommendations for further research.....	193
Concluding remarks.....	194
<b>References .....</b>	<b>196</b>
<b>Appendices .....</b>	<b>229</b>
Appendix A: Overview of EFT literature investigating use of EFT for physical health conditions .....	230
Appendix B: Ethics Clearance Certificate .....	238

# List of Tables and Figures

---

## List of Tables

- **Table a:** Overview of Emergent Themes presented in Results Chapters
- **Table b:** Overview of published works included in the thesis
- **Table 2.1:** The recovery model in mental illness healthcare (Whitley & Drake, 2010)
- **Table 2.2:** Sample List of EFT studies showing cross-section of populations and disorders explored
- **Table 3.1:** Participant Information: EFT Practitioners
- **Table 1.2:** Participant Information: Chronic Disease Patients
- **Table 3.3:** Overview of Research Findings
- **Table A1:** Summary of EFT literature investigating the use of EFT for physical health conditions

## List of Figures

- **Figure 1.1:** EFT Tapping Points
- **Figure 2.1:** The process of developing psychological predisposition to disease during childhood, then counteracting this by psychological changes in the adult life
- **Figure 3.1:** Methodological Framework for this study
- **Figure 8.1:** Using EFT to support chronic disease healthcare for patient as a whole-person

# List of Abbreviations/Acronyms

---

**AAMET:** The Association for the Advancement of Meridian Energy Techniques

**ACEP:** The Association for Comprehensive Energy Psychology

**APA:** American Psychological Association

**CBT:** Cognitive Behaviour Therapy

**CFS:** Chronic Fatigue Syndrome

**DoH:** Department of Health (Commonwealth)

**EFT:** Emotional Freedom Techniques

**EFTAP:** EFT Australian Practitioners Association

**EP:** Energy Psychology

**HIA:** Health Impact Assessment

**IPA:** Interpretative Phenomenological Analysis

**ME:** Myalgic Encephalomyelitis

**MUHREC:** Monash University Human Research Ethics Committee

**NREPP:** American National Registry of Evidence-based Programs and Practices

**PEAS:** Presentation Expression Anxiety Disorder

**TCM:** Traditional Chinese Medicine

**WHO:** United Nations World Health Organization

*This page has been intentionally left blank.*

# Chapter 1: Introduction

---

## Setting the scene

This study was borne out of a profound sense of dissatisfaction with the linear, one dimensional healthcare approach of modern day medicine; my perception of the modern-day healthcare approach being that the patient is viewed as a body to be treated, using objectively established ‘one size fits all’ care and cure mechanisms. I pondered that when every person is unique, with a unique life story, unique body, mind, and personality, how can a single method of treatment (physical, psychological, or allied) for a given illness fit every patient. Conversely, despite the individual differences among patients, there might be similarities in their experiences of illness, treatment and recovery, thus providing hope for other patients. This dissatisfaction has led me to further my exploration in the longstanding, but contended spheres of mind-body connection and holistic health.

Having been an enthusiast of holistic health and mind-body connection over the years, I have chased a subtle yet palpable self-awareness that there is more to illness and health than merely presence or absence of physical symptoms. In my travels through literature, discussions, as well as self-reflections on holistic health, I have come to also contemplate the nature of physical illness, and its relationship with the patient’s life-world. Some of the questions I have found myself asking include:

- How does a patient view their illness?
- How does a patient *feel* about their illness?
- Why did *this* person develop *this* illness at *this* time in their life?
- If illness is a case of misfortune, or even poor but conscious lifestyle choices, can a patient take more control of their health and wellness?

- What does ‘recovery’ from an illness look and feel like for a patient?
- If illness is simply the body’s physical response to a pathogen or other biological cause, can a patient return to their pre-illness state of being in this world once symptoms have receded?

As part of my personal inquiry in the area of health and illness, I have been particularly interested in exploring chronic illnesses; prolonged illnesses that cannot usually be resolved spontaneously, or cured completely (DoH, 2012). Complex and multifaceted in both causality and impact, with the ability to cause premature death or long-term functional impairment or disability, chronic illnesses pose physical, emotional and economic burden on people, families, and economies across the world. In light of complex care needs and often a lack of established and accepted medical cure, I have found myself wondering if a person with a chronic illness can lead a meaningful life that is in alignment with their personal values and priorities. In other words, without necessarily medically curing a condition, can a patient gain more control of their health, better manage their health condition, and “recover a life” (Slade, Amering, Farkas, et al., 2014, p. 14)? I contemplated whether a chronic illness patient can lead a ‘normal’ life, or at least reach some sense of normalcy in the face of an otherwise difficult life circumstance.

During my ‘crusade’ to further my personal understanding of health and illness, I came across a contemporary therapeutic tool, called Emotional Freedom Techniques (EFT), also known as ‘Tapping’. EFT combines principles of ancient Chinese acupuncture with Western psychotherapy, purportedly operating on the synergy between psychological exposure to an emotional trigger and a somatic acupoint stimulation component (Craig & Fowlie, 1995). The following section discusses this EFT therapeutic modality.

## Emotional Freedom Techniques: An Introduction

EFT belongs to a broader family of therapeutic techniques, referred to as ‘Energy Psychology’ (EP). EP is based on the principle of mind-body interconnectedness. The EP framework is underpinned by the relationships between neuro- and electrophysiological processes and mental functions (e.g., thoughts, emotions, behaviours) (ACEP, 2016). EP’s clinical applications include treatment of trauma, anxiety, pain, stress, psychophysiological issues, and depression (ACEP, 2016).

As noted previously, EFT combines principles of Chinese acupuncture with Western psychotherapy (Craig & Fowlie, 1995). EFT involves stimulation of certain acupuncture points on the face and upper body by gently tapping on them with fingertips, while the user is psychologically exposed to an emotional trigger (such as a traumatic memory or object of a phobia) (Boath, Stewart & Carryer, 2012a). The various Tapping points utilised in the EFT therapeutic process are shown in Figure 1.1. While gently tapping on the acupuncture points, and focusing on an emotional stimulus, the subject also voices statements of self-acceptance.

In a general ‘round’ of EFT, the user first rates the perceived intensity of a specific emotion, symptom or feeling and so on, on a scale of 0 to 10, where 0 is the lowest, and 10 is the highest. This score is called a ‘subjective unit of distress’ (SUD) score (Wolpe, 1958; Church, 2013). After that, the user focuses on that emotional stimulus, while tapping on the acupuncture points with finger tips. A setup statement is first used, while tapping on the ‘karate chop’ point located as the side of the hand (Refer Figure 1.1). The setup statement is informed by the emotional trigger that the user wishes to address. For example, if the user wishes to address a feeling of fear, the user may say the following setup statement: “Even though I have this fear, I deeply and completely love and accept myself”. Subsequently, the user taps on the remaining acupuncture points, while

continuing to focus on the emotion, and repeating a reminder phrase, such as “this fear”. This process is repeated until the intensity of the emotion decreases (Church, 2013).

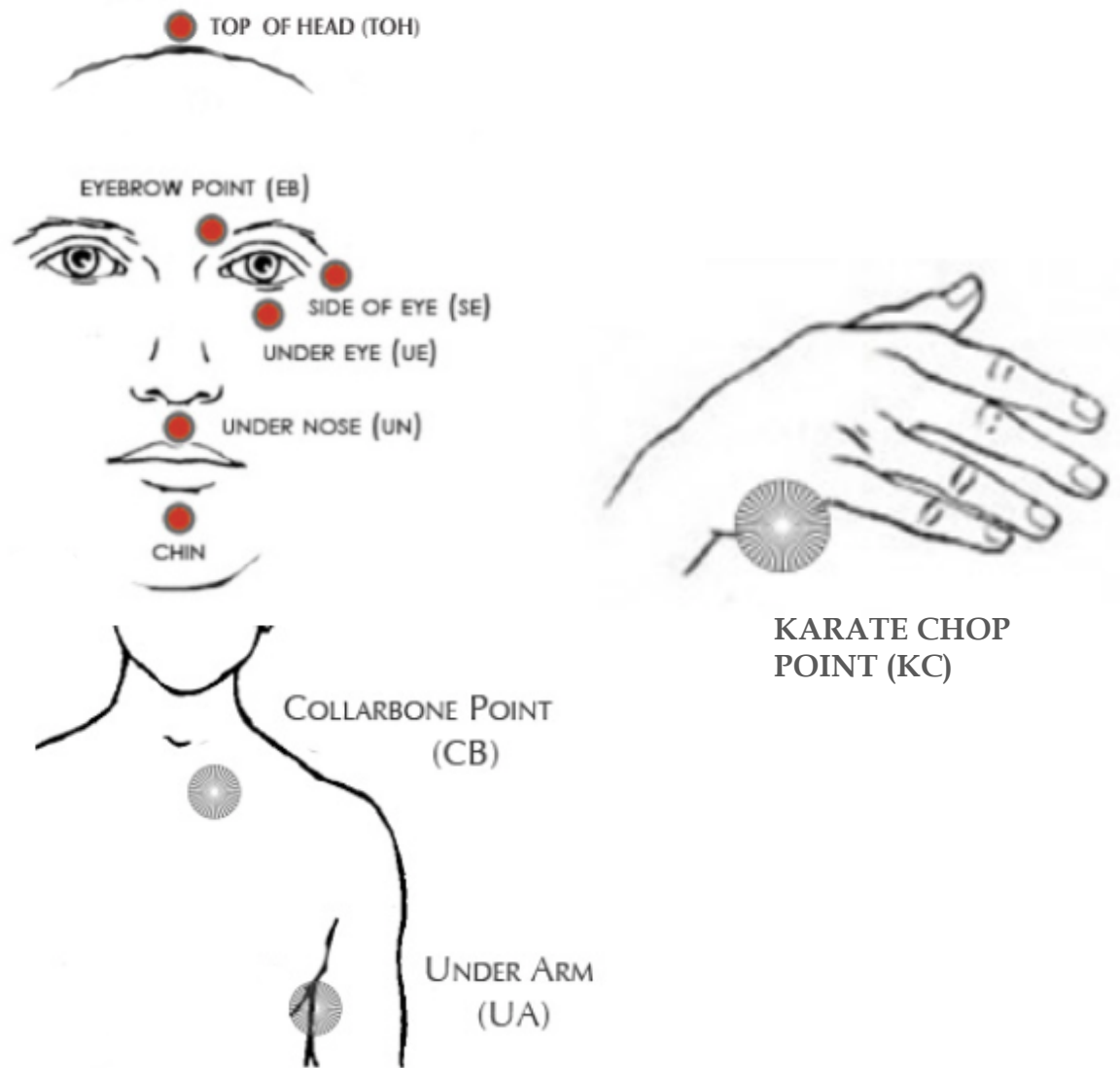


Figure 1.1: EFT Tapping Points (AAMET, 2017a)



In working through one emotion, the user may start to experience another emotion or remember another memory or trauma, which may or may not seem connected to the original trigger (Church, 2013). However, if the user follows their trail of emotions and memories, while tapping on the acupuncture points, a cognitive shift may occur. A spontaneous resolution or intensity reduction of negative thoughts, feelings, emotions and memories is often reported by users (Church, 2013).

There currently exist a variety of proposed hypotheses in relation to the mechanism of action in EFT. Diepold and Goldstein (2009) suggested that EFT has potential effects on the body's physiological systems that regulate stress, emotional intensity and associated neural transmission frequencies. According to Stapleton, Sheldon and Porter (2012a, p. 2), the combination of cognitive strategies with systems such as acupuncture creates a synergistic effect, leading to a shift in the “cognitive, behavioural, and neurochemical foundations of psychological problems”. Stapleton, Sheldon and Porter (2012b) also indicated that EFT appears to decrease activity in the amygdala, leading to calming of the ‘fight, flight, freeze, faint’ threat response to emotional triggers. Brattberg (2008) further suggested that similar to Cognitive Behavioural Therapy and Mindfulness, EFT relies on the premise that acceptance of, rather than resistance to, a particular condition or problem can reduce suffering (Brattberg, 2008).

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 (Clond, 2016; Nelms & Castel, 2016; Sebastian & Nelms, 2016). Several studies using quantitative data have also been conducted investigating the effects of EFT on physical chronic health problems such as tension headaches (Bougea, Spandideas, Alexopoulos et al., 2013), obesity (Stapleton, Sheldon & Porter, 2012a),

traumatic brain injury (Church & Palmer-Hoffman, 2014), chronic pain (Ortner, Palmer-Hoffman & Clond, 2014), and psoriasis (Hodge & Jurgens, 2011). However, there is a paucity of studies exploring users'<sup>1</sup> experiences of EFT using qualitative methodologies, particularly for chronic illnesses. There is limited qualitative literature on EFT for supporting PTSD care (Boath & Rolling, 2015), enhancing academic performance (Boath, Stewart, & Carryer, 2013) and reducing Presentation Expression Anxiety Syndrome (PEAS) in university students (Boath, Stewart, & Carryer, 2012b).

### **Chronic illness, EFT, and this study**

A number of clinician/user reported case studies demonstrating the use of EFT for a variety of chronic illnesses such as arthritis, diabetes, fibromyalgia, chronic fatigue syndrome, chronic pain, and asthma are available on electronic databases of EFT accreditation bodies (e.g. EFT Universe, 2017; Bharathan, 2014; Flegal; 2015; Ross, 2010). However, there appears to be limited academic research qualitatively exploring users' experiences of EFT for supporting chronic disease healthcare. As previously outlined, my reflections on patients' experiences of chronic illness and recovery led me to the psychotherapeutic tool of EFT. Realising that there is currently a paucity of data on users' experiences of EFT, particularly in relation to chronic disease healthcare, I became most interested in exploring patients' and EFT practitioners' experiences of using EFT to support chronic disease healthcare.

In order to lay the foundation of my research study exploring the aforementioned phenomena, I turned to theoretical conceptualisations of health and illness that corroborate the provision of psychotherapeutic support to people with physical illness. A literature review of

---

<sup>1</sup> The term 'user' implies both patients and EFT practitioners

several theoretical concepts underpinning this study, as well as an overview of EFT research published up to 2016 has been provided in the following chapter (Chapter 2). A review of theoretical concepts and extant literature on my chosen topic enabled me to define specific research objectives for this study. My research objectives are also presented in Chapter 2.

Having defined research objectives, the next step was to develop an appropriate methodological framework, which would be commensurate with the research aim and its theoretical underpinnings. The research methodology chosen for this study, along with the rationale for choosing said methodology, are detailed in Chapter 3. Upon explicating the study methodology, Chapter 3 also provides an overview of the study findings.

The findings emergent from the study are provided across four chapters (Chapters 4 – 7). This is a *thesis with published works*; three of the four results chapters (Chapters 4, 5, and 7) comprise journal articles published in peer reviewed academic journals. Chapter 6 has been presented as an unpublished thesis chapter due to it being lengthier than most journals' permissible word limits for articles. Finally, Chapter 8 presents a synthesis of the study's findings in light of the extant literature, discusses the study's implications for health practice, reviews the study's limitations, provides recommendations for further research and concludes the thesis.

## Chapter Summary

Chapter 1 set the scene for my PhD study. My PhD study was conceptualised from a personal dissatisfaction with current supposedly linear healthcare approaches that view the patient as a body to be treated. I have found myself contemplating the nature of physical illness, and its relationship with the patients' life-world. In particular, I have been interested in exploring literature on chronic physical illnesses. My explorations of holistic health led me to Emotional Freedom Techniques

(EFT), also known as ‘Tapping’. EFT is a contemporary therapeutic tool that combines principles of Chinese acupuncture with Western psychotherapy.

EFT has been applied to the treatment of both physical and mental health conditions. There are self-reported case studies by patients and EFT practitioners on the use of EFT for supporting chronic disease healthcare. However, there is currently a paucity of academic research exploring users’ experiences of EFT for supporting chronic disease healthcare. As such, through this study, I aimed to explore EFT practitioners’ and chronic disease patients’ experiences of EFT. Chapter 2 presents the extant academic literature in this area, and lays out the theoretical framework for this study. Chapter 3 presents the study methodology, and Chapters 4 – 7 present the emergent study findings. Chapter 8 presents a synthesis of the study’s findings and implications for research and practice, thereby concluding this thesis.

## Chapter 2: Literature Review

---

The previous chapter set the scene for my research study, contextualised the study against existing chronic disease research and practice, and introduced the therapeutic modality of EFT. The current chapter presents an exploration of extant academic literature in the areas of chronic disease healthcare, EFT, and recovery, relevant to my broad research aim. A literature review of several theoretical concepts underpinning this study, namely ‘the biopsychosocial model of health’, ‘mind-body co-emergence of disease’, and ‘the recovery model’ are provided in this chapter. Furthermore, an overview of existing academic literature on EFT published in peer reviewed journals is presented. An exploration of how a patient’s social environment may affect their health is also provided in light of certain ‘social determinants of health’. Subsequently, a gap analysis of existing literature is presented, and emergent research objectives are outlined.

### **Mind-Body Interconnectedness: The Biopsychosocial Model**

For most of the 20th century, health and illness were viewed from a biomedical perspective, which is based on a separation of the mind and the body. According to the biomedical model, the mind and the body are separate entities unique to each other (Descartes, 1952). According to Mehta (2011, p. 202), the mind is an “immaterial, but thinking substance”, whereas the body is a “material, but unthinking substance”. Ryle (1949) suggested that the body is subject to mechanical laws and the events happening to and inside the body are viewed as events happening in a person’s physical world. The events happening in, and to, the mind are considered to be part of a person’s mental world (Ryle, 1949). The biomedical model, based on a dualistic view of the mind and the body, sees humans as biological organisms, and disease as a departure from biological norms (Mehta, 2011).

According to the biomedical model, deviations from the biological norm are often a result of a chemical or physical occurrence and can be corrected using a physical or chemical substance. From a biomedical view, health came to be understood primarily as the absence of disease (Mehta, 2011). The biomedical model has what appears to be a linear view of disease, whereby diseases have a specific (usually single) biological cause, and a specific biomedical treatment. However, other models have emerged since the advent of the biomedical model. In the 1970s, George Engel suggested that disease must be viewed from a systems-thinking approach. Psychological and social aspects of an illness must be considered, in addition to the biomedical dimension (Engel, 1977). This came to be known as the ‘biopsychosocial model’ of health.

The biopsychosocial model is based on the premise that psychological and physiological processes are closely inter-linked. According to Sperry (2006), interactions of several biopsychosocial factors promote illness. Consequently, to restore and maintain health, several factors must be considered, including biological, psychological, social, environmental, and spiritual elements (Sperry, 2006; Hamilton-West, 2011). Even before the advent of the biopsychosocial model, researchers had provided evidence to show that stress, psychological conflict, and anxiety can lead to or aggravate disease processes (e.g. Alexander, 1950; Seyle, 1976). As such, mitigation of stress and/or psychological conflict can be expected to diminish disease processes (Pennebaker, Kiecolt-Glaser & Glaser, 1988).

The biopsychosocial model is referred to as the ‘mind-body connection’ in layperson language. An apt demonstration of the psychosocial factors of an illness is the prevalence of psychological co-morbidities such as depression, in people with chronic illnesses (Harvey & Ismail, 2008). According to the biopsychosocial model, the relationship between psychological and physiological processes may be considered “bidirectional” (Hamilton-West, 2011, p. 8). In other words, psychological factors can increase the risk of physical illnesses, and physical illnesses can

lead to psychological comorbidities (Hamilton-West, 2011). This model assumes that an imbalance in psychological and physiological processes results in ill health, and appropriately designed interventions that restore the balance between psychological and physiological processes can improve overall health outcomes (Hamilton-West, 2011). As such, the biopsychosocial view of health endorses the provision of psychotherapy (in case of this study, EFT), for supporting physical chronic disease healthcare.

The biopsychosocial model of illness has paved the way for the emergence of new fields of inquiry such as health psychology and psychoneuroimmunology (Hamilton-West, 2010). Health psychologists, for example, may endeavour to identify co-relations between psychological, biological and social factors in the aetiology of disease; and subsequently use this knowledge to develop, use and assess psychosocial interventions to improve people's health (Hamilton-West, 2011). Psychoneuroimmunology is another emerging field which studies the health implications of neural and biochemical interactions between the brain and the immune system (Hamilton-West, 2011). It looks at the impacts of positive and negative emotional factors on immunity, effects of stress on immune related diseases, as well as the influence of behavioural interventions on immune system parameters (Broom et al, 2011). Aside from these new areas of scientific inquiry, the idea of providing psychosocial support (e.g. EFT) to a physical chronic disease patient may be considered appropriate when taking a person-centred, rather than disease-centred approach to healthcare. Healthcare approaches which aim to move beyond disease-centred healthcare are further explored in the following section.

## Person-centred Healthcare

Healthcare approaches which aim to move beyond disease-centred healthcare, and integrate patients' individual needs have been discussed in the literature, under terms such as 'patient-centred care' (e.g. Stewart, 2001) and 'person-focused care' (Starfield, 2011). Different definitions of both terms exist. Starfield (2011) argued that 'patient-centred' healthcare differs from 'person-focused' healthcare. According to Starfield (2011), patient-centred care tends to be based on medical visits, and management of diseases, and may view different bodily systems as being separate from each other and the mind. Person-focused care, on the other hand, is based on the cumulative knowledge of the patient as a whole-person (Starfield, 2011). Person-focused care views bodily systems as being inter-connected and places disease episodes within the overall context of a patient's life-world (Starfield, 2011).

Stewart (2001) argued that the term 'patient-centred' healthcare while being commonly used in medical practice, is often poorly understood. Patient-centred care may be misunderstood as involving technology, doctor, or hospital centred healthcare (Stewart, 2001). Stewart (2001) suggested that patient-centred care pursues a cumulative understanding of the patients' life-worlds, such as their emotional needs and life issues, along with collaborative decision-making about care and treatment. Regardless of the diversity of terminology and definition, what is apparent in the literature is the identified need for more comprehensive healthcare approaches that surpass traditional disease-centred care.

For the purpose of this study, I have used the terms 'person-centred' and 'patient-centred' interchangeably to signify healthcare approaches which seek to operate from an integrated knowledge of the patient as a 'whole person'. It views the patient as an individual undergoing an illness experience, rather than as the target of a disease (Mead & Bower, 2000). In other words, it gives importance to a cumulative understanding of the patient's life-world, emotional needs, and



unique life circumstances (Starfield, 2011; Stewart, 2001). Whitley and Drake (2010, p. 1248) presented a comprehensive definition of person-centred care as being an approach that “attempts to perceive and assist the whole person in his or her social context, working with that person to provide help in a holistic and personally meaningful fashion”. A person-centred healthcare approach can thus help contextualise a patient’s required healthcare regime against the patient’s other needs.

The biopsychosocial model of health suggests that chronic disease patients may benefit from more ‘holistic’ healthcare that focuses not only on the biomedical dimension and the cessation of physical symptoms, but also on psychological and social aspects such as: the enhancement of overall well-being (Slade et al., 2014), improvement of their ability to engage in meaningful social and civic activities, and lead economically functional lives (Webb, 2012; Whitley & Drake, 2010). Some chronic illnesses (e.g. pulmonary diseases) can hamper patients’ ability to perform day to day tasks, such as continuing paid employment (Walker, 2010). This level of daily discomfort is likely to impact a patient on more than just a physiological level. The inability to undertake paid employment, and subsequent financial stress may leave people questioning their social identities, and experiencing a reduction in their self-esteem and a consequent sense of loss (Walker, 2010). In this scenario, the absence of psychological and social support can severely affect a patient’s quality of life and coping ability, and even result in comorbidities (Walker, 2010). As such, providing psychological support to chronic disease patients may be desirable and even necessary.

Coulter (2013) discussed the significance of understanding patients’ perspectives and experiences for provision of effective healthcare to patients. Coulter (2013) also proposes that the knowledge of patients’ experiences should be complemented by an understanding of practitioners’ experiences to yield effective patient-centred healthcare. Mead and Bower (2000) reviewed

conceptual and empirical literature to define several facets of a patient-centred practitioner-patient relationship. Mead and Bower (2000) identified the following five dimensions for understanding the process and outcomes of patient-centred healthcare:

- a biopsychosocial view of health;
- patient as a ‘person’, with a unique story and experiences;
- open sharing of responsibility between the patient and the health-care provider; and
- therapeutic collaboration and personal relationship between the patient and the health-care professional.

The provision of psychotherapeutic support (e.g. EFT) to physical chronic disease patients may therefore be considered to be in alignment with person-centred healthcare approaches. There is literature suggesting several applications of psychological interventions for management of physical illnesses. For example, psychological interventions may be administered for alleviation of pain to patients undergoing surgery (Hamilton-West, 2011). Heinrich, Monstadt and Michel (2009) discussed the provision of psychotherapy for chronic back pain, based on a biopsychosocial model of pain. Heinrich et al. (2009) suggested that thoughts that elicit or exacerbate pain can impact patients’ illness behaviour. As such, self-monitoring of maladaptive thoughts, feelings and behaviours by patients can help them improve their wellbeing and coping abilities (Heinrich et al., 2009). Another study conducted by Ventegodt, Thegler, Andreasen et al. (2007) found that psychodynamic psychotherapy administered to people with physical illnesses led to improvements in self-assessed quality of life, self-assessed mental health, ability to work, and personal relationships.

Furthermore, albeit an old study, Pennebaker et al. (1988) introduced a noteworthy aspect of the relationship between psychotherapy and physical illness, namely, prevention. Pennebaker et al. (1988) found that actively addressing past upsetting or traumatic experiences may be beneficial

for physical health, including enhancing immune function, as well as improving subjective distress. The aforementioned study was based on the idea that withholding or inhibiting feelings and thoughts is associated with chronic stress and illness. Consequently, by actively seeking to ‘face’ a traumatic or upsetting experience, a person may be able to reframe the experience, and develop a more empowering perspective or meaning about the experience (Pennebaker et al., 1988).

Ventegodt et al. (2007) investigated the effects of short-term psychodynamic therapy and bodywork on patients with physical illness (mainly chronic pain). Psychodynamic therapy was administered with the goal of helping patients address emotional pain associated with childhood trauma(s) (Ventegodt et al., 2007). The study’s participants reported improvements in self-assessed mental health, personal relationships, quality of life, and ability to work (Ventegodt et al., 2007). There are several models and hypotheses in the literature which allude to the association of chronic stress with causation and progression of physical illness, and the importance of addressing feelings and emotions related to difficult life situations for physical healing. These are discussed in greater detail in the following section.

### **Mind-body Co-Emergence of Disease**

The previous section outlined the applications of psychological support for physical illnesses, and emphasised that psychotherapy can have much wider impacts (e.g. prevention) than previously thought (e.g. coping with illness). To exemplify this further, a preliminary study conducted by Cunningham and Watson (2004) warrants consideration. This study suggests that psychological therapy may prolong survival in cancer patients. Cunningham and Watson (2004) interviewed ten individuals who had outlived their cancer prognoses by up to 12.5 years. The aim of the interviews was to find out common themes in psychological attributes of these people. It is acknowledged

that this study by Cunningham and Watson (2004) represents preliminary exploratory research in the area; the findings nonetheless merit consideration in the context of my research aim.

The rationale behind Cunningham and Watson's (2004) study was that if there are commonalities in the psychological attributes of long-term cancer survivors which may have potentially contributed to their survival, perhaps psychological interventions can be designed and administered to other patients to achieve similar qualities and improve chances of survival. In order to compare the psychological attributes of long-term survivors with those who did not live much longer than their prognoses, the authors retrospectively used interview scripts of 12 people who had died at approximately the expected prognosis time. These 12 people had been interviewed by the authors for a previous study.

While analysing the main psychological attributes of the long-term survivors, three main themes emerged from the interviews: authenticity of thought and action, perceived autonomy to live life as per personal values, and acceptance of self and others (Cunningham & Watson, 2004). One participant said that while the experience of cancer was initially shattering, the participant gradually came to realise that this experience helped them 'grow as a person'. Participants claimed that they worried much less about what other people thought, found it easier to say "no", developed closer relationships, made better decisions, and enjoyed life more.

On the other hand, the people who had not outlived their prognoses, had mainly talked about the chaos cancer had caused in their lives, their distress because of the disease, and desperation to heal physically. There was also no mention of holistic healing in the way long-term survivors had described. The long-term survivors also apparently demonstrated experiences of "peacefulness, joy, greater self-understanding, more sharing, less conflict with others, as well as a

greater sense of meaning in life and spiritual connectedness”, traits which were missing in the accounts of people who did not outlive their prognoses (Cunningham & Watson, 2004, p. 224).

Cunningham and Watson (2004) reviewed literature that suggests that chronic stress, such as excessive fear, continual anger, or depression experienced while growing up may negatively impact the body, and contribute to development of a predisposition to disease later in life. However, emotional adaptation through psychological support can oppose disease progression and prolong survival (Cunningham & Watson, 2004). The chronic stress-induced wear and tear of the body has been named ‘allostatic load’ by McEwen and Stellar (1993).

McEwen and Seeman (1999) suggested that stress hormones and allostatic load contribute to physiologic changes which render the body susceptible to disease. Cunningham and Watson (2004) propose that just as a high allostatic load can negatively impact the physical body, a reduction in the allostatic load through psychological healing work, may result in better quality of life, longevity, and improvement in physical health. Cunningham and Watson (2004) argued that the participants interviewed in their study who had outlived their disease prognoses had likely done so due to psychological adaptation and living a life of ‘authenticity’ and ‘autonomy’. The aforementioned process of developing psychological predisposition to illness and subsequent psychological adaptation to promote health, is illustrated in Figure 2.1.

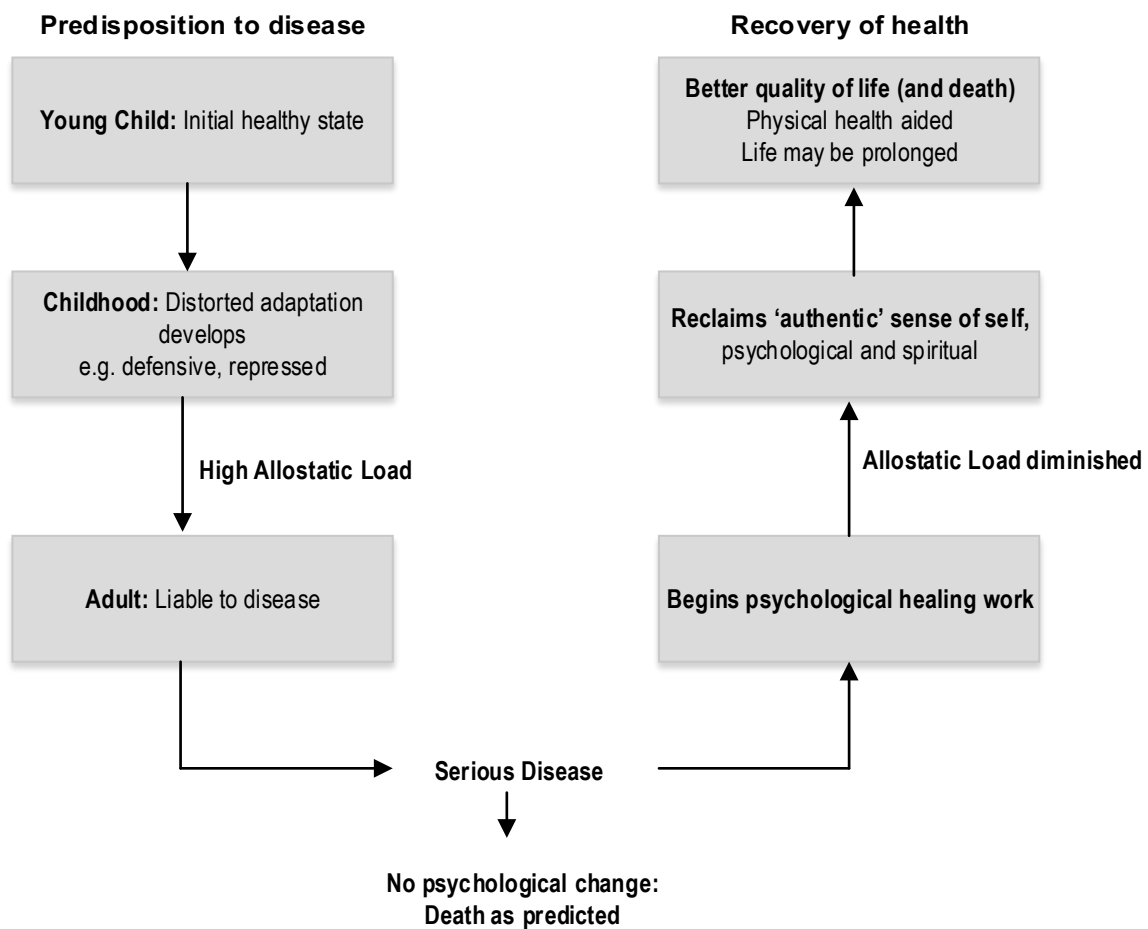


Figure 2.1: The process of developing psychological predisposition to disease during childhood, then counteracting this by psychological changes in the adult life (Cunningham & Watson, 2004, p. 226)

### *Beyond mind-body dualism: Personhood and Symbolic Disease*

Having explored literature on mind-body interconnectedness, it is also worthwhile to note an alternate perspective offered by Broom, Booth and Schubert (2011) that also lends itself to my research topic. Broom et al. (2011) suggested that rather than considering mind and body as separate entities as discussed previously in this chapter, it may be beneficial to see them as representations of the ‘observed’ and ‘experienced’ aspects of personhood. Adopting a personhood view of illness, Broom (2002) discussed a phenomenon namely, ‘symbolic disease’. Symbolic disease represents a scenario where the pathology of organ systems affected or involved in, (clinical phenomenology of a disease) has an apparent congruence or semblance with the

*Tapping into Recovery: Exploring Experiences of EFT*

patient's life story, history, personal meanings, and behaviours (Broom, 2002). Broom et al. (2011) suggest that in adopting a personhood view of an illness, one must concurrently consider both the bodily diagnosis ('body'), and the patient's meanings about their life/experiences ('mind'). In other words, the concept of 'symbolic disease' postulates that a disease is a somatic representation of the person's life-world, including their life history, personal history and meanings. As such, a disease may be viewed as a repository of meaning, conceived from a patient's life history, personal stories, experiences, meanings and subjectivity (Broom et al., 2011).

Stemming from the aforementioned personhood view, is the model of 'mind-body co-emergence of disease' (Broom et al., 2011). This model entails the notion of the 'whole-person', characterised by a reciprocity between physicality ('body') and subjectivity ('mind'), wherein physicality and subjectivity of a disease are inter-connected and have resonances in each other (Broom, 2007). Several researchers acknowledge that the current methodologies of clinical and medicine research and practice do not allow much scope for understanding patients' individual stories and meanings (Broom et al., 2011; Buckley, Corless & Mee, 2016; Hawkins & Lindsay, 2006).

Therapeutic interventions, such as EFT in the present study, may thus help patients retell their life stories, and make sense of their personal meanings, and illness experiences, and understand their disease symbology. In the text, 'Meaning-full Disease', Broom (2007) presented clinical experiences from his immunological practice, whereby he posits that dealing with emotional issues associated with patients' illness symbology was linked with remission of the physical condition. However, when viewing illness from a personhood, or even a biopsychosocial perspective, remission of physical symptoms may only constitute one aspect of recovery from illness. If a person's life-world is taken into account, understanding 'recovery' may require a

multidimensional, multi-perspectival framework. This is discussed in greater detail in the following section.

## **The Recovery Model**

A new approach to chronic disease management has transpired in the last couple of decades, namely the ‘Recovery Model’. The recovery model suggests that a person may be able to ‘recover’ from an illness, despite the illness not being fully ‘cured’ (Anthony, 1993). This model suggests that recovery may represent different things for different people, and should extend beyond the pursuit of cure (Harvey & Ismail, 2008). The pursuit of recovery may entail improvement in the overall quality of a patient’s life, including the ability to engage in meaningful socio-economic activities and lead a life in accordance with what the patient holds important (Lieberman & Kopelowicz, 2005; Mueser, Corrigan, Hilton et al., 2002).

The recovery model originally emerged for use in the context of chronic mental illness healthcare, however, some argue that it is also applicable to chronic physical illness healthcare (Harvey & Ismail, 2008). Harvey and Ismail (2008) posited that care for chronic physical illnesses differs substantially from care for acute physical illnesses, in that chronic illnesses can often be life-long, and require patients to make several adjustments to the way they previously lived their lives. Furthermore, psychological problems interact with physical health conditions, thus providing psychological support is crucial for effective management of chronic physical health conditions (Harvey & Ismail, 2008). Care for what may be a life-long health condition, should not only involve reduction of symptoms, but also assist patients in leading fulfilling and functional lives. Chronic physical illness healthcare may involve facilitation of holistic outcomes, such as hope, fulfilment, improved social function and relationships, self-efficacy and occupation, which are all facets of the mental illness recovery model (Harvey & Ismail, 2008).



While literature on similar multi-dimensional conceptualisations of recovery is relatively scarce in literature on chronic physical illness healthcare, the term ‘recovery’ appears to have been sporadically used in the context of physical illness healthcare. For example, a meta-analysis was conducted to review the effects of emotional wellbeing on survival and long-term recovery in people with physical illnesses (Lamers, Bolier, Westerhof, Smit & Bohlmeijer, 2012). Lamers et al. (2012) used several functional and health status related measures to define ‘recovery’ outcomes. The outcome measures (e.g. a self-reported questionnaire known as EuroQol-5D) chosen to define ‘recovery’ included aspects such as the ability to perform daily life activities independently, social relationships, mood (anxiety/depression), self-care etc. Lamers et al. (2012) found that improved emotional wellbeing may have positive effects on physical disease prognoses. Peterson, Park and Seligman (2006) also present linkages between recovery and strength of character in physical illness patients.

Harvey and Ismail (2008) argued that a multi-dimensional recovery model that goes beyond cessation of symptoms towards achievement of holistic outcomes and enhancement of a patient’s overall wellbeing and quality of life may be a more effective approach for management of chronic physical illness. Borrowing concepts of recovery from mental health literature and using these as a basis for exploring chronic physical illness patients’ perspectives on recovery may therefore be considered reasonable. This adoption of the recovery model for the current study also appears befitting in light of a biopsychosocial view of health, and an overall personhood approach to healthcare. Webb (2012) concurred that ‘recovery’ represents individualised meanings, and thus recovery processes should be based on principles of person-centred healthcare, rather than disease-centred healthcare.

Whitley and Drake (2010) reported a five-dimensional model of recovery, comprising clinical, existential, functional, physical and social dimensions. While originally developed with the

view of mental illness healthcare, this model also appears to have an application for chronic physical illnesses, in light of the above discussion. An overview of this model is provided in Table 2.1 followed by further explaining of its elements in the context of chronic physical illnesses. This multi-dimensional model of recovery lends itself to the exploration of users' experiences of EFT for supporting chronic disease healthcare, in the context of a person-centred healthcare approach and a biopsychosocial view of health.

**Table 2.1: The recovery model in mental illness healthcare (Whitley & Drake, 2010)**

Component	Description
<b>Clinical</b>	Subsidence or control of symptoms to a point that they are either perceived as no longer extant, or manageable by patient.
<b>Existential</b>	Sense of self, personal empowerment. Includes hope, responsibility, self-direction, autonomy and self-efficacy. Often underpinned by spirituality and religion.
<b>Functional</b>	Ability to participate in daily life (e.g. employment, education), integration in the socio-economic life.
<b>Physical</b>	Enhancement of overall physical health and wellbeing, may include incorporation of healthy lifestyle choices (e.g. exercise, nutrition)
<b>Social</b>	Meaningful and enriching social and interpersonal relationships, active citizenship, and engagement with the broader community.

**Clinical Recovery:** Clinical recovery mainly relates to the subsidence or control of symptoms to a point that they are either perceived to no longer exist, or can be managed by the patient to a significant degree. Clinical recovery may be managed and driven by medical practitioners, including both general practitioners, and psychological therapists (Whitley & Drake, 2010). While clinical recovery is underpinned by the medical model, it may also be influenced by the other four dimensions of the recovery model.

**Existential Recovery:** Existential recovery relates to a ‘sense of self’ and personal empowerment. It includes hope, responsibility, self-direction, autonomy and self-efficacy. Existential recovery means having a good locus of control of illness rather than feelings of helplessness or feeling controlled by illness (Whitley & Drake, 2010). Existential recovery is often underpinned by spirituality and religion. In fact, according to Büssing and Koenig (2010), for chronic disease patients, spirituality and religion can serve as important coping mechanisms. Patients who have to deal with chronic symptoms can often struggle with questions about the meaning of life and face religious or spiritual struggles. Therefore spiritual support can be valuable for enhancing quality of life of patients suffering from long-term chronic illnesses (Büssing & Koenig, 2010).

**Functional Recovery:** Functional recovery signifies the ability to fully participate in various aspects of one’s daily life such as employment and education, and improved integration in socio-economic life. This in turn may also provide lateral benefits such as higher self-esteem, improved morale and social relationships (Whitley & Drake, 2010).

**Physical Recovery:** Physical recovery means enhancement of the physical health and well-being of a person. A person with a chronic physical illness may need support with making healthy lifestyle choices (for e.g. nutrition, support with physical exercise) that support recovery. Physical recovery may require a holistic approach that is supported by allied health professionals such as nutritionists and physical therapists.

**Social Recovery:** When people with chronic illnesses do not feel adequately emotionally supported, it can exacerbate their existing psychological distress and cause more severe problems such as anxiety and depression (Büssing & Koenig, 2010). People with chronic illnesses may feel isolated, and have trouble maintaining healthy relationships with family, friends and peers. In general, it is common for patients with any kind of chronic symptoms to feel emotions of guilt,

sadness, and grief around the loss of their health, work or relationships and so on as a result of their illness. They may also have difficulty communicating their feelings about their problems with their family and friends (Büssing & Koenig, 2010). They may also feel negative emotions because of their perceived inability to contribute to the lives of their family, friends, children, and workplaces. Social recovery refers to the reinstatement of meaningful and enriching social and interpersonal relationships. It is not limited to immediate family relationships and friendships, but also encompasses active citizenship and engagement with the community (Whitley & Drake, 2010). Social recovery may be facilitated by friends, family, professionals such as social workers, as well as by community and spiritual leaders.

These five dimensions of the recovery model are interlinked, and usually growth or improvement in one of these facets may create a domino effect, positively influencing the other dimensions. For example, procurement of a meaningful and rewarding employment opportunity (*functional recovery*), can lead to increased engagement with the community and broadening of social networks (*social recovery*), which in turn, can improve a person's sense of self and empowerment (*existential recovery*) (Whitley & Drake, 2010). Farkas (2007) conducted a review of first person accounts of recovery in people with major mental illnesses, and other research to clarify the meaning of 'recovery', and concluded:

Recovery research has shown that recovery is possible over time; represents a multidimensional, highly individualized non-linear process that can be described; may be achieved with or without professional intervention; has multiple objective and subjective outcome indicators that reach beyond symptom reduction. (p. 70)

In light of the aforementioned recovery model, which advocates for the improvement of personal empowerment, social relationships, self-esteem, emotional wellbeing and lifestyle choices, besides physical symptom management, provision of psychological support appears to hold a useful place in physical chronic illness healthcare. The biopsychosocial view of health, and the recovery model

both point to the significance of psychological support for physical chronic disease healthcare. The psychological intervention chosen for exploration in this study is the contemporary therapeutic tool, EFT. A brief overview of the EFT intervention was provided in the previous chapter. The following sections provide an overview of the history of this intervention, and subsequently a synopsis of published scientific literature on EFT.

### **History of Emotional Freedom Techniques**

The origins of EFT lie in Traditional Chinese Medicine (TCM) (AAMET, 2017b), which is over 2500 years old (NCCIH, 2010). One of the most popular TCM practices, acupuncture, is based on the energy meridian system, on which EFT is also based. In acupuncture, practitioners use needles to activate the meridian end points, also called acupuncture points (Carrington, 2012; AAMET, 2017b).

Acupuncture was originally developed to treat physical problems. EFT, on the other hand, is often referred to as ‘emotional acupuncture’ (Craig & Fowle, 1995). The coining of this phrase can be attributed to the work of an American chiropractor George Goodheart. Upon being introduced to acupuncture, Goodheart decided to incorporate it into his own practice of Applied Kinesiology, which involves muscle testing to determine suitability of a treatment (Carrington, 2012; AAMET, 2017b). Goodheart found that applying manual pressure on the meridian end points was just as effective as using needles. As this was a non-invasive treatment method, it became popular among practitioners and patients (Carrington, 2012).

In the 1970s, Australian Psychiatrist John Diamond built on Goodheart’s work and introduced a new component to Applied Kinesiology developing its modified version, Behavioural Kinesiology. This variation involved stating positive affirmations while applying manual pressure

on selected acupressure points. Diamond supposedly used this technique to assist his patients with emotional problems. Behavioural Kinesiology can be considered to be the major precursor of EP techniques, such as EFT (Carrington, 2012).

Psychologist Roger Callahan, who specialised in anxiety disorders, studied Applied Kinesiology and acupuncture. He combined the use of tapping acupressure points with focusing on a given problem or emotional trigger. He used this treatment for patients with phobias and found that fears often resolved spontaneously by tapping acupressure points while they focused on the fear. Callahan found from experimentation that different problems had to be treated with different acupoint tapping sequences (Carrington, 2012; AAMET, 2017b). He posited that these sequences could be found via the use of muscle testing. Callahan developed a series of tapping protocols which became targeted treatments for different emotional problems and named this method of treatment, The Callahan Techniques, and later, Thought Field Therapy (TFT) (Carrington, 2012; AAMET, 2017b). While Callahan allegedly achieved clinical benefits through this method, it had limitations. Muscle testing to identify the unique tapping sequence was reportedly a cumbersome process as well as needed trained practitioners to achieve satisfactory results (Carrington, 2012).

Some practitioners and students of TFT suspected that unique protocols for different problems may not be necessary and a single protocol may produce comparable benefits for patients. Thus, in 1987, Patricia Carrington developed a single protocol called 'Acutap' in which she asked clients to tap on all acupressure points without using any diagnostic process, such as muscle testing (Carrington, 2012). Callahan's student, Gary Craig, subsequently developed a single protocol using 12 acupressure points which he reportedly began applying to both psychological and physical health problems. Gary Craig is considered to be the founder of EFT and has been teaching EFT since the early 1990s (Carrington, 2012; AAMET, 2017b).

The EFT treatment protocol has been described in manuals authored by Craig and Fowle (1995) and Church (2013b). EFT trainings for both self-care and practitioner certification are provided through professional associations such as The Association for the Advancement of Meridian Energy Techniques (AAMET), The Association for Comprehensive Energy Psychology (ACEP), and EFT Universe. An overview of extant EFT research published in peer reviewed academic journals has been provided in the following section.

### **Using EFT to support physical illness healthcare**

Several quantitative research studies investigating the use of EFT for physical and mental health conditions have been published in peer reviewed journals (refer Table 2.2). The use of EFT has also been studied for a wide range of populations. A list of example references of EFT studies conducted across a cross-section of populations and disorders is provided in Table 2.2. The information provided in Table 2.2 portrays a sample of the published EFT literature, and does not represent an exhaustive list. Subsequently, however, a summary of studies (published to my knowledge until 2016) investigating the use of EFT to support physical illnesses is provided in Appendix A. Other studies exploring the use of EFT for mental disorders (e.g. PTSD) or other uses (e.g. athletic performance), as shown in Table 2.2, were considered to be outside the scope of this thesis.

I acknowledge that this study is based on the biopsychosocial model of health, and a personhood approach to healthcare, which dictates that mental and physical health are co-related. However, for succinctness, this section focuses on the use of EFT to support physical illness healthcare only, in line with the present study's overall aim. The studies exploring EFT's uses for physical illness healthcare may however include investigation of EFT's application for

psychological symptoms. For example, a study evaluating EFT's use for a physical illness (e.g. psoriasis) may also include review of improvements in quality of life and/or psychological distress.

The literature presented in this section comprises studies published until the year 2016. Physical health conditions which have been explored in EFT literature include: pain disorders, psoriasis, traumatic brain injury, obesity, fibromyalgia, and cancer. An overview of these studies' findings as reported by their authors, has been provided in Appendix A. Methodological issues or shortcomings of the studies have not been evaluated. A review of EFT literature, as provided in Table 2.2 and Appendix A suggests that most of the EFT research conducted to date encompasses quantitative/experimental methodologies. As previously noted, there appears to be a paucity of EFT research conducted using qualitative methodologies. Limited qualitative literature exists on EFT for issues such as PTSD (Boath & Rolling, 2015), academic performance (Boath, Stewart, & Carryer, 2013) and PEAS (Boath, Stewart, & Carryer, 2012b). However, there does not appear to be any qualitative academic research exploring EFT in the context of chronic physical illnesses. An overview of the search strategy adopted for this literature review has been provided herein.

This review incorporated published studies written in the English language. The search encompassed electronic databases, direct contact with researchers, research listed on professional association bodies (e.g. ACEP, AAMET, EFT Universe). Studies published between 2000 and 2017 were considered for this review. EFT emerged in the early 1990s (Carrington, 2012), but was not published in the academic literature until the late 1990s/early 2000s. The starting date (2000) was picked to ensure a degree of currency in the chosen literature.

The following steps in the search strategy were employed:

1. An initial search on the electronic database Medline, with the key word "Emotional Freedom Technique\*". The results generated by this search were scanned for additional key words.



2. Using those key words identified, a number of electronic databases were searched.
3. Reference lists of identified papers were scanned to search for additional studies.
4. Eftuniverse.com and the Association for Comprehensive Energy Psychology (ACEP) websites were searched for research.
5. Personal contact was made with international researchers to gain access to additional studies whose full text was not found on the web.
6. Some journals publishing information on energy psychology are not yet indexed with major databases. One such journal which has a large amount of published literature on this topic is Energy Psychology. This journal was hand searched separately.

The databases that were searched include:

- Medline
- PsychINFO
- CINHALL
- Embase
- Compendex
- Web of Science

Below is a list of the key words selected for the search. The key words were chosen based on the target population and intervention:

- Population (P): anxiety, stress, mental illness\*, disease\*, chronic disease\*, psychosomatic disease\*
- Intervention (I): Emotional freedom technique\*, acupoint\*, energy psychology, meridian-based, energy medicine

For example, in Medline, all the key words under population and intervention were searched individually and subsequently linked together (population keywords together and intervention key words together) using the OR function. Finally, the population and intervention searches were connected using the AND function.

Reviews of EFT research conducted by Feinstein (2012), and Church (2013a) indicated that EFT has been found to be an ‘evidence-based’ practice for anxiety, depression, phobias and PTSD when measured against the standards of the American Psychological Association’s (APA) Division 12 Task Force on Empirically Validated Treatments<sup>2</sup>. As of 2017, EFT is currently under review for efficacy by the American National Registry of Evidence-based Programs and Practices (NREPP). TFT, the precursor of EFT, briefly mentioned earlier in this chapter, has been accepted by the NREPP as being ‘effective’ for trauma and stress-related disorders, self-regulation, and personal resilience/self-concept, and ‘promising’ for depression, phobias, panic and anxiety disorders, and general functioning and wellbeing (NREPP, 2016).

**Table 2.2: Sample List of studies showing cross-section of populations and disorders explored in EFT research**

Population/Disorder	References
<b>Populations</b>	
<b>College students</b>	Church, De Asis & Brooks, 2012
<b>Veterans</b>	Church, Hawk, Brooks, Toukolehto, Wren, Dinter & Stein, 2013 Geronilla, McWilliams & Clond, 2014
<b>Pain patients</b>	Bougea et al., 2013 Church & Nelms, 2016
<b>Overweight adults</b>	Stapleton, Bannatyne, Porter, Urzi & Sheldon, 2016 Stapleton, Church, Sheldon, Porter & Carlopio, 2013 Stapleton et al., 2012a
<b>Hospital patients</b>	Karatzias, Power, Brown et al., 2011
<b>Athletes</b>	Church, 2009 Llewellyn-Edwards & Llewellyn-Edwards, 2012
<b>Healthcare workers</b>	Church & Brooks, 2010
<b>Gifted students</b>	Gaesser, 2016
<b>Chemotherapy patients</b>	Baker & Hoffman, 2014
<b>Phobia sufferers</b>	Wells, Polglase & Andrews, 2003 Baker & Siegel, 2010

<sup>2</sup> The APA Division 12 (Clinical Psychology) has defined explicit research and evidence criteria for judging the efficacy of interventions.

Population/Disorder	References
	Salas, Brooks & Rowe 2011
<b>Disorders</b>	
<b>General anxiety</b>	Andrade & Feinstein, 2004
<b>Dental anxiety</b>	Temple & Mollon, 2011
<b>Test anxiety</b>	Benor, Ledger, Toussaint, Hett & Zaccaro, 2009 Boath, Stewart & Carryer, 2013 Jain & Rubino, 2012; Sezgin, Ozcan & Church, 2009
<b>Public speaking anxiety</b>	Jones, Thornton & Andrews, 2011
<b>Phobias</b>	Baker & Siegel, 2010 Wells et al., 2003
<b>PTSD</b>	Burk, 2010 Church, 2009b Church, Geronilla & Dinter, 2009 Church et al., 2013 Church & Brooks, 2014 Church, Pina, Reategui & Brooks, 2011 Gurret, Caufour, Palmer-Hoffman & Church 2012; Hartung & Stein, 2012 Karatzias et al., 2011 Stein & Brooks, 2011
<b>General trauma</b>	Lubin & Schneider, 2009 Swingle, Pulos & Swingle, 2005
<b>Stress</b>	Bougea et al., 2013 Church & Brooks, 2010 Church, Yount & Brooks, 2011 Rowe, 2005
<b>Depression</b>	Chatwin, Stapleton, Porter, Devine & Sheldon, 2016 Church, De Asis & Brooks, 2012 Stapleton, Church, Sheldon & Porter, 2013 Stapleton, Devine, Chatwin, Porter & Sheldon, 2014
<b>Addiction</b>	Church & Brooks, 2013 Palmer-Hoffman & Brooks, 2011
<b>Obesity / emotional eating / food cravings</b>	Stapleton, Sheldon, Porter & Whitty, 2011 Stapleton, Sheldon & Porter, 2012a, 2012b Stapleton, Chatwin, William, Hutton, Pain, Porter & Sheldon, 2016 Stapleton, Bannatyne, Urzi, Porter & Sheldon, 2016
<b>Pain Disorders, Fibromyalgia, Tension headaches</b>	Bougea et al., 2013 Brattberg, 2008 Ortner, Palmer-Hoffman & Clond, 2014
<b>Frozen shoulder</b>	Church & Nelms, 2016

Population/Disorder	References
<b>Psoriasis</b>	Hodge & Jurgens, 2011
<b>Insomnia</b>	Lee, Chung & Kim, 2015
<b>Seizure disorders</b>	Swingle, 2000
<b>Sporting / athletic performance</b>	Church, 2009a Church & Downs, 2012 Llewellyn-Edwards & Llewellyn-Edwards, 2012 Rotherham, Maynard, Thomas, Bawden & Francis, 2012
<b>Learning disabilities / educational</b>	McCallion, 2012
<b>Epigenetic and physiological functioning</b>	Church, Yount, Rachlin & Nelms, 2016 Maharaj, 2016

Having provided an indicative sample of EFT studies published until the year 2016, a more comprehensive overview of EFT research investigating the use of EFT for physical health conditions is provided in Appendix A. Two other noteworthy aspects of some of the studies presented in Table 2.2 and Appendix A that merit acknowledgement, are the use of EFT as a self-care tool, and the administration of EFT via the internet/telephone (e.g. Brattberg, 2008; Baker & Hoffman, 2014). The use of EFT as a self-care method, and its application via the internet/telephone may have implications for the social dimension of health, for example, access to healthcare services, personal behaviours, and social support, and consequently be useful in the exploration of my broader research aim.

Having discussed the psychological aspects of health in the previous sections, and the psychological intervention under consideration in this study (EFT), the ‘social’ aspect of health also merits consideration in light of the biopsychosocial model of health. For the purpose of my study, the exploration of the social dimension of health has been undertaken through the lens of certain social determinants of health, as defined by the United Nations World Health Organization

(WHO). The WHO determinants of health have been reviewed in the context of EFT's practice of telephone/internet delivery, and self-administration in the following section.

### **The social aspect of healthcare: Determinants of Health**

The United Nations World Health Organization (WHO) identifies various factors which cumulatively impact the health of people and communities. These factors, also known as 'determinants of health' represent the conditions and circumstances in which a person is born, grows up, works, and lives (WHO, 2016). These factors may not always be within a person's direct control. Determinants of health include environmental conditions, genetics, personal relationships, income, education level, as well as access to health services among others. In assessing the impacts of a proposed policy or program, WHO and its affiliated organizations may utilize a tool known as the Health Impact Assessment (HIA). HIAs may assist decision-makers in evaluating the potential of a proposed initiative's impacts on a population's health. The determinants of health are often taken into account in these health impact assessments while evaluating the prospective benefits of a proposed health initiative. Broadly, WHO categorises determinants of health into the following three types:

- social and economic environment;
- physical environment; and
- individual characteristics and behaviours.

WHO further elaborates seven determinants of health, as follows (WHO, 2016):

1. Income and social status: higher income/social status is associated with greater health. The larger the gap between the richest and poorest in a population, the greater will be the health disparity.

2. Education: Lack of education is linked with poorer health, greater stress and lower self-confidence.
3. Physical environment: This includes access to clean water and air, safe and healthy working conditions, and the availability of infrastructure such as roads.
4. Social support networks: Support from family, friends and the broader community is associated with greater health. This determinant also encompasses cultural aspects such as traditions and customs, and familial and community beliefs.
5. Genetics: This determinant not only includes genetic inheritance, but also personal behaviours, coping mechanisms, lifestyle habits, and general ability to deal with life's stressors and challenges.
6. Health services: Access to health services plays a major role in prevention and treatment of disease.
7. Gender: Men and women experience different illnesses, and at different ages.

The provision of EFT therapy by practitioners to patients via telephone and/or internet, and self-application of EFT may hold relevance for some of the aforementioned determinants of health, namely 'genetics' (primarily personal behaviours and coping mechanisms), 'health services', 'physical environment', and 'social support'. These select determinants which appear to hold relevance for telephone/online delivery, and self-administration of EFT, are discussed as follows.

### *Genetics (Individual behaviours and coping)*

As noted previously, WHO includes individual health behaviours and coping mechanisms under the determinant of 'genetics'. Given that personal behaviours, coping mechanisms, and lifestyle habits hold most relevance for my study, particularly in the context of use of EFT for self-care, this section primarily elaborates on the aforementioned aspects. Genetic inheritance, however, is

considered to be outside the scope of this study, and has therefore, not been discussed in this section.

Thorne, Patterson and Russell (2003) noted the importance of everyday self-care by patients to reduce the burden on health services. A large-scale community study was conducted involving 831 participants, aged 40 years and older with heart disease, lung disease, stroke or arthritis to understand the impact of a low cost program for promoting self-management in people with diverse chronic diseases (Lorig, Ritter, Stewart et al., 2001). Data was measured at baseline and then at one and two year intervals. Over the course of the program, participants' health status (self-rated health, disability, social/role activities limitations, energy/fatigue, and health distress), and perceived self-efficacy improved and healthcare utilisation (ER/outpatient visits, times hospitalised, and days spent in hospital) reduced. The study showed that self-management can improve the health status of chronic disease patients, and reduce healthcare costs, and consequently the illness burden on healthcare services (Lorig et al., 2001). Self-administration of EFT for self-care of patients may thus have implications for coping and health behaviours, in line with the aforementioned WHO determinant of health.

### *Health Services and Physical Environment*

Delivery of EFT via the internet and/or telephone may have implications for supporting patients who are unable to access services due to geographical or other barriers. Telephone-delivered EFT could have an application for residents of areas with limited telecommunications/internet infrastructure. This accessibility may hold particular relevance for people residing in rural areas. According to Strasser (2003), the general health of rural people across the world is worse than that of urban people. A number of factors contribute to this, particularly, access to health services and information, and shortage of qualified health professionals in rural areas (Strasser, 2003). Even in countries where a large part of the population is rural, resources and services may be concentrated

in city centres (Strasser, 2003). Apart from delivery of EFT via telephone or internet, self-administered EFT may also hold relevance for patients facing difficulty in accessing health services due to their physical environment or otherwise.

### *Social support*

Apart from diagnosis and formal treatment, chronic disease patients may also need medical information, social support, counselling services, and help with overall symptom management to maintain a good quality of life. Such services are often limited in rural areas, for example (Cudney, Butler, Weinert & Sullivan, 2002). Feeling isolated from social support, information, and health services may impact patients' ability to cope with their illnesses (Cudney et al., 2002). As such, the ability to access support via telephone or the internet may assist patients improve their coping ability.

### *Gap analysis and direction for this study*

My review of EFT literature (as per the search strategy outlined previously in this chapter) highlighted that there is limited academic research on users' experiences of EFT for supporting chronic disease healthcare. A number of self-reported cases are available on the online database at EFTuniverse.com. However, to this point, there appears to be little academic research that uses qualitative data for exploring users' experiences, as is used in my study. Additionally, the effects of EFT on other physical chronic health problems such as Chronic Fatigue Syndrome (CFS), digestive disorders, autoimmune conditions (e.g. arthritis), pulmonary conditions, etc. also appear to be unexplored in academic research, at least as of 2016. As such, the present study aims to qualitatively explore users' experiences of EFT to support physical chronic disease healthcare. Therefore, the broad research aim for the present study was articulated as to:



## **Explore EFT practitioners' and chronic disease patients' experiences of using EFT to support chronic disease healthcare**

Furthermore, according to the underpinning theoretical concepts such as symbolic disease and the recovery model, helping patients make sense of their illnesses, and their personal notions of recovery may hold value for a person-centred healthcare approach. As a therapeutic tool, EFT may be used to help facilitate patients' meaning-making of their illness and recovery experiences. Additionally, it emerged that telephone/internet delivery and self-administration of EFT may have implications in the context of the WHO determinants of health. In light of the above, the specific research objectives that transpired from a review of extant literature were to explore:

- EFT practitioners' perceptions and experiences of using EFT to support chronic disease patients;
- chronic disease patients' personal symbolic meanings of their illnesses as emergent from their experience of EFT therapy;
- chronic disease patients' personal notions of recovery; and
- The usefulness of telephone/internet delivery and self-administration of EFT in the context of the WHO determinants of health.

Having laid out the study's aim and objectives against the backdrop of existing literature, the next step was to identify an appropriate methodological framework to explore the aforementioned study objectives, and design congruent research methods for conducting the research. The following chapter discusses the chosen appropriate methodological framework, and data collection and analysis methods. Emergent findings from the study are discussed thereafter.

## Chapter Summary

Chapter 2 set the theoretical framework for this study, and reviewed current academic literature on EFT. This study is underpinned by a biopsychosocial view of health, and a personhood approach to healthcare. EFT's delivery via telephone/online mediums, and self-administration of EFT by patients may have implications for the social dimension of health; for example, people facing geographical barriers to access of support services, may be able to receive telephone-delivered EFT support.

There appears to be a paucity of academic qualitative literature exploring users' experiences of EFT. As such, this study aims to explore EFT practitioners' and chronic disease patients' experiences of using EFT to support chronic disease healthcare. The following chapter (Chapter 3) will set the methodological framework for the exploration of the research aim and objectives which were defined in this chapter. Chapter 3 will also outline the research methods used to collect and analyse data to address my research aim and objectives, introduce the study's participants, and provide an overview of the emergent findings before a detailed exploration of the findings in the subsequent results chapters.

# Chapter 3: Study Methodology

---

The previous chapter established the theoretical framework for this study. It reviewed theoretical concepts underpinning the study and current academic literature on EFT. A review of EFT literature indicated a paucity of academic research exploring patients' and practitioners' experiences of using EFT to support chronic disease healthcare. Additionally, theoretical concepts underpinning this study such as the biopsychosocial model of health, and personhood approach to healthcare, suggest that exploration of patients' and health practitioners' experiences are important for strengthening any health practice. As such, the current study was designed to fill an important gap in the EFT literature, to explore practitioners' and patients' experiences of using EFT to support chronic disease healthcare.

A qualitative research orientation lends itself to the detailed study of human experience allowing for the exploration of subjective individual experiences; and was therefore considered apposite for addressing the research aim. There currently exist a variety of methodological paradigms in the qualitative research tradition. This chapter will outline key features of qualitative research, detail the chosen methodological framework and research methods used in this study, introduce the study's participants, and present an overview of the emergent research findings to set the context for the forthcoming results chapters.

## Salient Features of Qualitative Research

Qualitative research aims to deliver rich and detailed understanding of a given context or research aim. Because rich and detailed descriptions underpin qualitative research, qualitative studies play a crucial role in creating an in-depth representation of a given subject or research topic (Barbour, 2008). Qualitative studies rely heavily on inductive processes and give due importance to

*Tapping into Recovery: Exploring Experiences of EFT*

subjectivity. Hence qualitative data can be useful in exploring research questions pertaining to human behaviour, opinions, and experiences (Guest, Namey & Mitchell, 2013).

Qualitative studies also acknowledge the close association of the researcher and the researched, as well as the contextual or situational opportunities and limitations that underpin a research study (Denzin & Lincoln, 2008). Therefore, it is important for the researcher to position themselves in the research, and acknowledge prior experiences, opinions and perceptions which may influence both the conduct of the research, and the findings. My positionality within this research study is discussed in later in this chapter.

Another important feature of qualitative research is that it is fluid (Green & Thorogood, 2014). In a qualitative study, the various research steps such as literature review, data collection, and analysis often overlap and require the researcher to have a degree of flexibility in their research strategy (Green & Thorogood, 2014). As an example of this flexibility, a research strategy may entail increasing or decreasing the sample size, or asking impromptu questions to participants during interviews to gain more depth in the data.

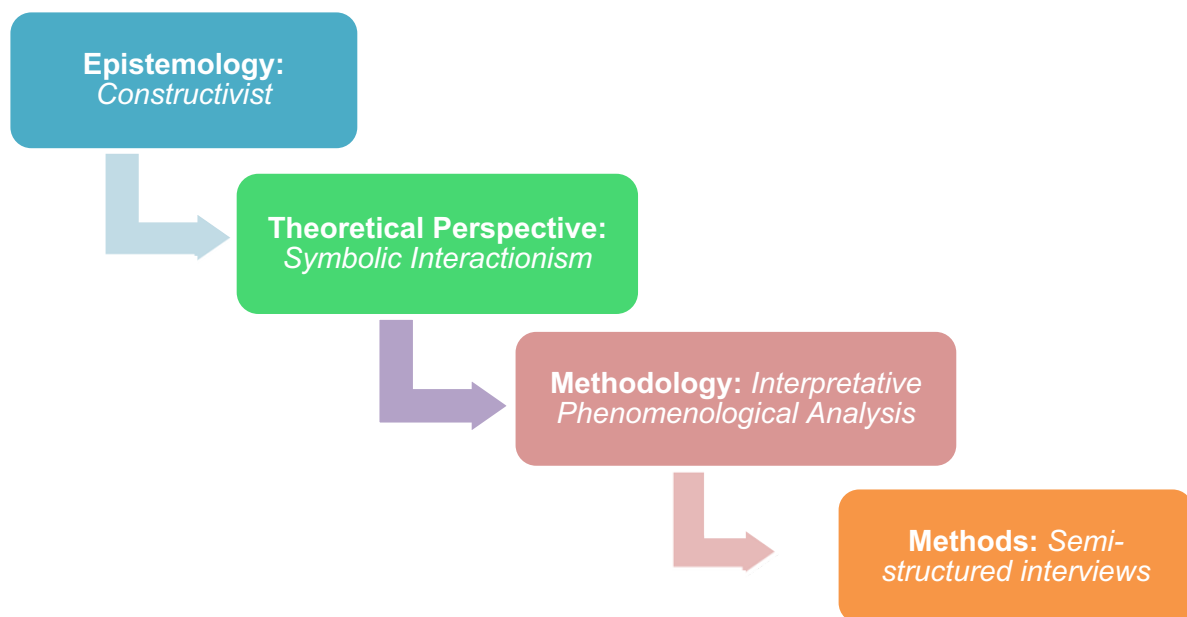
Qualitative research encompasses a breadth of epistemological positions and methodological traditions. The relationship between a qualitative research aim and its epistemological and methodological underpinnings can be considered cyclical. The research aim guides the choice of a suitable epistemological position, methodological approach and research methods (Carter, 2007). Furthermore, the epistemic and methodological choices also shape the research aim. Carter (2007) emphasised the importance of ensuring commensurability between the research aim, epistemological position, methodological approach, and choice of methods to strengthen the quality and rigour of qualitative research. The methodological framework chosen for this study is explored in the following section.

## Methodological Framework

The methodological framework used in this study is derived from the research process outlined by Crotty (1998). This process comprises four elements namely, epistemology, theoretical perspective, methodology and methods. The methodological framework represents a hierarchical structure based on the assumption that each component informs the following component. In other words, each element can be seated within the previous element. For example, the data collection method of semi-structured interviews can be used for a number of different research methodologies (such as interpretative phenomenological analysis or narrative analysis). These methods can be underpinned by various theoretical perspectives (such as symbolic interactionism or phenomenology), which in turn are situated within a particular epistemological standpoint (such as radical constructivism or social constructionism) (Crotty, 1998). The methodological framework for this study is shown in Figure 3.1, and discussed as follows:

1. **Epistemology:** Epistemology refers to the theory of knowledge (Crotty, 1998). In other words, epistemology refers to the various modes of knowing the world (Green & Thorogood, 2014). Epistemology helps us identify what kind of knowledge can be achieved and considered valid (Feast & Melles, 2008). Examples of epistemological positions include constructivism, objectivism, and subjectivism, among others.
2. **Theoretical Perspective:** Theoretical perspective refers to the theoretical standpoint which informs a study's methodology (Crotty, 1998). The theoretical perspective is compatible with the epistemological stance, underpins the logic and criteria of a methodology and guides the methodological processes (Crotty, 1998). Examples of theoretical perspectives are post-modernism, symbolic interactionism, and feminism (Feast & Melles, 2008).

3. **Methodology:** Methodology refers to the plan or approach to conducting research. A methodology forms the link between research objectives and the appropriate research techniques and methods (Crotty, 1998). Examples of methodologies include discourse analysis, interpretative phenomenological analysis, and narrative analysis (Feast & Melles, 2008).
4. **Methods:** Methods are the specific practical tools and techniques used in the research process for data collection and analysis (Crotty, 1998). Examples of data collection methods include focus groups and semi-structured interviews. Examples of data analysis include thematic analysis and content analysis (Feast & Melles, 2008).



**Figure 3.2: Methodological Framework for this study**

The chosen epistemology for the current study is constructivism, with a symbolic interactionist theoretical perspective. Interpretative Phenomenological analysis was chosen as the research methodology, with semi-structured interviews as the data collection tool. Each of the elements of

Crotty's (1998) aforementioned framework, in the context of the current study are explored in the following sections.

### **Epistemological position: Constructivism**

The previous section provided a theoretical definition of epistemology. A constructivist<sup>3</sup> epistemological position was assumed for this research study. Various meanings and versions of the constructivist theory exist in literature, depending on the theorist's position and context (Jones & Brader-Araje, 2000). While the definition of constructivism may vary according to the theorist and context, broadly, a constructivist perspective suggests that individuals actively engage in meaning-making and construct knowledge, rather than passively receiving it (Jones & Brader-Araje, 2000). The common thread running through the various philosophical meanings and theories of constructivism is the active part played by an individual in meaning-making and knowledge generation (Jones & Brader-Araje, 2000).

Swiss psychologist, Dr Jean Piaget, is often considered to be a founding figure of the constructivist theory (Jones & Brader-Araje, 2000). Piaget (1967) talked about constructivism in the context of individual learning. Piaget (1967) emphasised the active part played by an individual in the learning process. Piaget (1967) also suggested that individuals constantly reconstruct and update new knowledge in light of new experiences. Therefore, reality is viewed as being a constant construction actively undertaken by an individual, rather than a collection of pre-existing structures of truth and meaning (Piaget, 1970).

---

<sup>3</sup> Constructivism is often conflated with constructionism; however they represent different epistemologies. Gergen and Gergen (2008) explain that constructivism is primarily associated with the "processes inherent in the individual mind" (p. 160); whereas constructionism deals with inter-subjective and "relational processes" (p. 164).

Constructivism suggests that individuals do not passively consume data, but they use that data to construct impressions and meanings (Schwandt, 2007). In other words, individuals construct, rather than discover meanings (Grey, 2014). There are a wide variety of schools of thought in relation to how these meanings are constructed (Schwandt, 2007). Some broad examples of how these meanings are theorised to be constructed include interpersonal interactions, cultural beliefs and practices, language, history and personal interpretation (Schwandt, 2007). Several varieties of constructivism are extant in literature, such as radical constructivism, social constructivism, and critical constructivism. For the purpose of the present study, a radical constructivist approach was adopted as the epistemological position.

Radical constructivism, as proposed by philosopher Ernst von Glasersfeld, recognises the role of an individual's subjective interpretation of their experience (Jones & Brader-Araje, 2000). Von Glasersfeld's (1995) constructivist view posits that people receive knowledge through their senses and/or communication, and interpret and actively construct their reality based on their experiences and interactions with their environment. In other words, knowledge is not transmitted from one person's mind to another's. Instead, it is up to the person to interpret their experiences in accordance with their personal references of what is viable. Therefore, according to von Glasersfeld, the true reality about 'what actually occurs' cannot be known, because "knowledge does not reflect an objective, ontological reality but exclusively an ordering and organization of a world constituted by our experience" (von Glasersfeld, 1984, p.24).

Von Glasersfeld (1989) argued that cognition is adaptive, i.e. it helps people organise their experiential world-reality, rather than discover an absolute truth, or objective reality. As noted before, constructivism postulates that the meanings created by people are continually tested against previous knowledge and either reinforced or modified in line with new experiences (Schwandt, 2007). Von Glasersfeld (1995, p. 7) proposed the concept of 'viability', wherein the focus is not



on an absolute truth that accurately matches an objective reality, rather, “concepts, models, theories, and so on, are *viable* if they prove adequate in the contexts in which they were created”.

Having discussed meaning-making and the testing, reinforcement, and modification of those meanings, it is also worth contextualising psychotherapy (and for the current study, EFT), within a constructivist thought paradigm. Constructivist psychotherapeutic styles have emerged in the post-modern world, which are characterised by exploratory, creative and intensely personal approaches that aim to facilitate changes in patients’ personal narratives and general constructs as opposed to instructive disorder-specific and corrective traditional cognitive approaches (Neimeyer, 1993). A discourse on the placement of psychotherapy, in particular EFT, within a constructivist thought paradigm is presented in the following section.

### **Constructivism in Psychotherapy and EFT**

Mahony and Granvold (2005) discussed the influences of constructivism in psychotherapy. Influences of constructivism can also be observed in the EFT approach, which also makes constructivism an appropriate epistemology for the exploration of EFT experiences. An overview of this analysis is provided as follows:

#### ***Exploration and resolution of early life issues***

The previous chapter discussed Cunningham and Watson’s (2004) theory of development of psychological predisposition to disease during childhood. This theory was based on the premise that chronic stress experienced while growing up can result in the development of a predisposition to disease from childhood. Early life events are also often explored and addressed in many psychotherapeutic approaches, including EFT (Church & Marohn, 2013).

From an epistemological standpoint, constructivism posits that children act as ‘scientists’ who make sense of their world and adapt to their environment based on the meanings they have constructed in their minds (Piaget & Cook, 1952). Further, according to some psychological theories, children may construct unproductive meanings or decisions about themselves, other people, or the world, in light of a perceived threat or negative experience (Young, Klosko & Weishaar, 2003). In some psychotherapeutic approaches, these meanings are referred to as ‘early maladaptive schemas’. Early maladaptive schemas are “self-defeating, emotional and cognitive patterns established from childhood and repeated throughout life” (Young et al., 2003, p. 6). Early maladaptive schemas can be viewed as ‘filters’ constructed in early life, through which an individual may see his/her subsequent life experiences, and thus reinforce that previous meaning (Young et al., 2003).

Some consider that early maladaptive schemas often stem from unmet emotional needs as a child that can cause unhealthy patterns later in life, such as addictions, health problems or other mental health issues (Young et al., 2003). Unmet emotional needs could be a result of suboptimal parent-child relationships/interactions or adverse life circumstances (such as loss of a close elder/parent) among other experiences. Once constructed, these meanings and related patterns of behaviour can deeply entrench themselves into people’s lives (Mahony & Granvold, 2005). According to the constructivist philosophy, different people may have different reactions to the same event, and different interpretations of the same phenomenon (Grey, 2014). This variety of reactions to, and interpretations of, the same event can be attributed to the concept that we all construct our realities against the backdrop of different meanings we have created and experience our lives in accordance with these meanings.

### *Construction of new meanings*

Constructivist psychotherapy relies on the reorganisation or transformation of people's meanings and constructions about themselves and their social relationships. These approaches aim to help patients and their therapists collaborate to make sense of patients' lived experiences through an interpretative process, and to co-construct positive or more productive meanings about seemingly difficult experiences or circumstances (Mahony & Granvold, 2005). EFT is also often used to help 'reframe' the meanings given by individuals to their circumstances to help them view their lives from an alternative, more positive lens and facilitate healing (Church & Marohn, 2013).

### *Client as a change agent*

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 (Bohart, 2000). For example, Grencavage 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. Bohart (2000) argued that the client is an active self-healing agent who receives the therapist's input and adapts it to achieve his/her/own ends. According to Bohart (2000), the therapist is a facilitator for the client, and therapeutic process is best focused on collaboration and dialogue.

Constructivist psychotherapies emphasise that humans are active participants in their lives and capable of self-efficacy (Mahony & Granvold, 2005). Therefore, a constructivist approach to psychotherapy sees the client as an active change agent who can drive the therapeutic process in collaboration with a therapist possessing clinical expertise, and not as a passive recipient to whom therapy is administered (Mahony & Granvold, 2005). In EFT, the therapist is often viewed as a facilitator and like other constructivist approaches, emphasis is placed in the 'wisdom' of the client (Church & Marohn, 2013; Mahony & Granvold, 2005; Neimeyer, 1993).

In the EFT approach, the therapeutic process is usually guided by the client's emotional and thought trail (Church & Marohn, 2013). 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 (Church & Marohn, 2013). 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 (Beck, 1964). 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 the emergent thought/emotion trail and aim to resolve whichever memories or emotional triggers surface for the client (Church & Marohn, 2013). The recommended use of EFT for self-care by patients also corroborates the 'client as a change-agent' premise of constructivist psychotherapeutic approaches.

### *Outlook towards emotions*

Neimeyer (1993) suggested that traditional cognitive therapies view negative emotions as arising from distorted thinking, and as problems that need to be resolved, or at least controlled. On the other hand, in constructivist psychotherapeutic approaches, negative emotions are seen as informative tools which can act as valuable signs of challenges to existing constructions. In EFT, as described previously, the therapist often follows the client's trail of emotions, facilitating the Tapping process until there is a perceived reduction in the intensity of that emotion. In other words, the client's emotional trail is seen as a guide in the EFT therapeutic process.

Mahony and Granvold (2005) also argued in the context of constructivist therapies that feelings and emotions are pivotal to the human experience, and that resisting one's feelings can negatively impact health and well-being. Therefore, a person's relationship with his/her emotions and feelings can be as significant as those feelings themselves (Mahony & Granvold, 2005). Based

on a similar premise, EFT is also often used to facilitate acceptance of negative emotions in individuals (Church & Marohn, 2013).

### **Theoretical Stance: Symbolic Interactionism**

Symbolic interactionism is a theoretical perspective that is often associated with constructivism and falls under the broader umbrella of interpretivism. This theoretical perspective was born out of the need for theorising human behaviour with practical reality and lived experience at its nucleus (Cooley, 1902; Mead, 1934). George Herbert Mead is considered one of the founding figures of the symbolic interactionist theory (Grey, 2014). The term ‘symbolic interactionism’ however, was coined by George Herbert Mead’s student, Herbert Blumer (1969). Blumer (1969) posited three main tenets associated with the symbolic interactionist theory:

- Humans act towards situations based on the meanings humans have imparted to the situations.
- These meanings are typically the result of social interaction.
- Meanings are not constant. Meanings are modified during social interactions, when the individual communicates with the self and upon self-reflection reinforces, rejects, or modifies meanings.

The aforementioned tenets of the symbolic interactionist theory also appear congruent with the EFT therapeutic approach. For example, this theory posts that meanings are not constant and may be modified during social interactions, and in light of new experiences. In an EFT session, a therapist may assist the client make sense of his/her meanings, and facilitate reframing of negative or unproductive meanings to construct new positive meanings.

Literature suggests that the view of social interaction in symbolic interactionism is compatible with the fundamental processes of social interaction in radical constructivism (Thompson, 2000). In particular, both symbolic interactionism and radical constructivism posit that meaning is not communicated from one person to another. Instead, when a person communicates a meaning to another person, the listener attributes meanings to the utterances of the speaker in accordance with the listener's own understandings and personal meanings (Thompson, 2000).

According to the symbolic interactionist theory, the meanings that people have ascribed to their experiences, can be understood only through an interpretative process (Grey, 2014). Therefore, in order to develop an appreciation for a person's meaning-making and subsequent behaviour, the researcher must attempt to understand the participant's unique perspective through an interpretative approach (Grey, 2014). The theoretical framework described above (radical constructivist view combined with a symbolic interactionist theoretical perspective) invoked the need for a research methodology that can combine meaning-making in a lived experience context with an interpretative aspect. Interpretative Phenomenological Analysis (IPA) was deemed as a suitable methodology in light of the aforementioned rationale. Further information on the IPA methodology is provided in the following section.

### **Chosen Methodology: Interpretative Phenomenological Analysis**

The methodology chosen for this research project was Interpretative Phenomenological Analysis (IPA). This methodology was developed by professor of psychology Jonathan Smith, with the objective to enable meticulous investigation of individual or unique subjective experiences (Smith, Flowers & Larkin, 2009). The primary goal of this methodology is to explore meaning and context with the view to enable an understanding of the complexities of lived experience (Brocki &

Wearden, 2006). IPA was initially developed as an approach to experiential qualitative research in psychology, however it has since been applied to other disciplines such as human, social and health sciences (Smith et al., 2009; Smith, 2010). It is important to acknowledge that because IPA is a relatively contemporary methodology, the literature on the applications and processes of IPA is still emerging. One key IPA text currently exists written by Smith et al. (2009), which has extensively been used for development of this study's methodology, and consequently cited widely within this thesis.

IPA is considered apposite for studies, such as the current research project, which are underpinned by or related to biopsychosocial theories of health (Biggerstaff & Thompson, 2008). A large part of published IPA studies relate to this area of health psychology which aims to shed light on the “constructed nature of illness”, rather than the traditional biomedical models (Brocki & Wearden, 2006, p. 88). With the advent of a biopsychosocial model of illness, health professionals are realising the significance of understanding patients' perceptions and experiences of their diseases and treatments. How patients make sense of and interpret their experiences of disease, diagnosis, and treatment is therefore increasingly being recognised as an important area for research. IPA allows researchers to help strengthen the understanding of patients' subjective experiences (Brocki & Wearden, 2006). IPA is primarily underpinned by three main theoretical pillars, namely:

- Phenomenology: The study of lived experience
- Hermeneutics: The science of interpretation
- Idiography: The focus on unique facts/individual cases, or study of specifics

IPA is phenomenological in that it is concerned with the study of lived experience and hermeneutic in that it proposes that knowledge or understanding of that experience can be developed 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 (Smith, 2010). The following sections describe the aforementioned three theoretical cornerstones of IPA, including both a general description of the disciplines, as well as how each of them fits in to the context of IPA.

### *Phenomenology*

Phenomenology is a philosophical approach to the exploration and understanding of human experiences (Smith et al., 2009; Crotty, 1998; Todorova, 2011). Phenomenological inquiry, put simply, means the examination of a ‘thing’ or ‘experience’, in its own terms. In other words, phenomenology implies that if we can temporarily suspend our preconceptions or general understandings about the world, and its objects that we may otherwise take for granted, we may be able to construct new meanings or enhance existing meanings of phenomena (Crotty, 1998). Over the years, the understanding of phenomenology has evolved through the work of a number of philosophers and thinkers, as described below.

Philosopher Edmond Husserl was the founder of phenomenological inquiry (Larkin, Watts & Clifton, 2006). Husserl suggested that in order to more accurately understand our experience, we must replace our ‘natural attitude’ (our everyday unrecognised or taken-for-granted attitude/perception of things) with a ‘phenomenological attitude’ (perceiving things from a metaphorical ‘clean slate’). In order to adopt a phenomenological attitude, researchers must ‘bracket’ or temporarily suspend their existing knowledge/habits of thought about phenomena (Smith et al., 2009; Crotty, 1998).

Husserl’s work has informed IPA in that it helps IPA researchers to focus on reflection and systematically examine their own lived experiences. However, IPA differs from Husserl’s traditional phenomenology, in that Husserl’s approach attempts to uncover an unadulterated



essence of experience (Smith et al., 2009). Husserl's approach may be considered to have an essentialist underpinning which is not commensurate with my chosen constructivist epistemological position.

The IPA methodology, which aims to depict specific experiences as experienced by specific people, is most influenced by the phenomenological viewpoints posited by Husserl's student and mentee, Martin Heidegger (Smith et al., 2009). Heidegger postulated that it is impossible for people to disengage with their fore-conceptions (e.g. previous experiences, assumptions and so on). From Heidegger's perspective, a person is permanently situated within a context (Larkin et al., 2006); in other words, we cannot choose to temporarily suspend our relationships with the various objects that constitute our world. Heidegger dismissed the Cartesian divide between subject and object and suggested that we are a fundamental part of a meaningful world, and that world is a part of us (Larkin et al., 2006). Therefore, we and our world can be better understood as a product of our engagements or associations with each other (Larkin et al., 2006). Heidegger's aforementioned perspective also appears commensurate with the theoretical underpinnings of my research topic, such as the 'personhood' view of a patient, which sees the patient as a whole-person embedded in a unique set of circumstances and life-world.

The primary ideas from Heidegger that influence IPA are, firstly, humans beings can be thought of as being embedded into a world of different objects, language, and relationships; and secondly, our being and experiences of the world are always perspectival and relational (Smith et al., 2009). Consequently, Heidegger proposes an interpretative phenomenological approach which differs from Husserl's assumption-devoid descriptive phenomenology (Smith et al., 2009; Biggerstaff & Thompson, 2008). While acknowledging the seminal works of early theorists such as Husserl, for the purpose of this study, Heidegger's hermeneutic phenomenology will be the focus.

Heidegger's hermeneutic phenomenology forgoes the idea of bracketing and introduces a reflexive approach to questioning the researcher's fore-conceptions. Consequently, the practice of bracketing was not adopted for this study, as a thorough and effective bracketing exercise was deemed implausible, as per Heidegger's view of the researcher as permanently being situated in a context, and a constructivist epistemology. Instead, a reflexive approach was adopted for this study to allow my personal biases and fore-conceptions to emerge throughout the research process. Further discussion on Heidegger's hermeneutics theory, along with my positioning as the researcher in this research and reflexive purposes adopted for this study, will be provided later in this chapter. However, prior to that, further exploration of other phenomenologists' works and their influences on the IPA methodology is detailed as follows.

Another key thinker in phenomenological inquiry, Merleau-Ponty (1964) echoed Heidegger's beliefs to some extent. However, Merleau-Ponty added that humans view themselves as being different from the world and everything else in it. In other words, humans see themselves as being individually whole and thus engage with the world as such, rather than as being incorporated or embedded within the world. Merleau-Ponty proposed that the human body is an individual's means of communicating with the world (Merleau-Ponty, 1964). The term 'lived body' is often used to describe the notion of an individual's body as experienced by them (Toombs, 1988).

The IPA methodology often views an individual as being "a body in the world" (Amos, 2016, p. 309) and sees the lived body as shaping individuals' fundamental views on, and understanding of their worlds (Amos, 2016; Smith et al., 2009). Furthermore, the notion of the lived body dictates that our sense of ourselves and others is based on our embodied nature. For example, while we may be able to observe and empathise with another person's pain, we cannot fully share the other person's experience because their experience belongs to their own body-

subject or embodied nature (Smith et al., 2009; Merleau-Ponty, 1964). IPA also acknowledges the need for interpretation to understand other people's relationships with their life-worlds, and meanings generated as a factor of them being a body in the world (Amos, 2016; Smith et al., 2009). Furthermore, the phenomenological notion of the lived body may also lend itself to the exploration of 'symbolic disease', as per my second research objective (to explore chronic disease patients' personal symbolic meanings of their illnesses as emergent from their experience of EFT therapy).

Sartre was another phenomenological thinker who further contributed to phenomenological inquiry of lived experience by proposing that human beings are not pre-existing 'units' which can be discovered or their 'true' essence known (Smith et al., 2009). Instead, humans are constantly in a state of 'becoming'. Sartre's viewpoint is commensurate with the constructivist epistemological position used in this thesis, according to which reality is a constant active construction and reconstruction undertaken by an individual, rather than a collection of pre-existing structures of truth and meaning (Piaget, 1970). Furthermore, Sartre's viewpoint as described here may also lend itself to the exploration of participants' experiences, particularly in relation to the notion of 'recovery' and 'becoming well' following an illness.

In summary, over a period of time, phenomenologists have moved from a transcendental focus (Husserl) to a more interpretative and worldly approach aimed at generating a perspectival understanding of people's involvement with a meaningful, lived world. IPA aims to understand just this: people's relationships to their meaningful world; and adopts an interpretative approach to do the same. Further information on the science of interpretation, hermeneutics is provided in the following section.

## *Hermeneutics*

Hermeneutics is the science of interpretation; it is concerned with the methods and purposes of interpretation. Hermeneutics was originally used in the interpretation of biblical texts and subsequently historical documents and literary works (Smith et al., 2009). A number of hermeneutic theorists have added different dimensions and knowledge to this area of study. According to the theorist, Schleiermacher, interpretation spans two dimensions: grammatical, which relates to the precise impartial meaning, and psychological, which is associated with the individuality of a person (Smith et al, 2009, p 22). Schleiermacher further indicates that a comprehensive and thorough analysis of data can provide a researcher rich understanding of the participant. In the context of IPA, for instance, detailed analyses of the participants' responses can provide researchers with meaningful in-depth information that is not only obvious from the participants' categorical claims or enunciations, but also transcends the information provided (Smith et al, 2009; Larkin et al., 2011).

However, in order to enable this level of interpretation, the researcher must share a common ground with the participant or person who is being interpreted (Smith et al, 2009; Larkin et al., 2011). In other words, IPA is most suited to insider research, where the investigator researches a peer group or a community that he/she is a part of. The current study can be considered to fall under the umbrella of insider research. As an EFT user, I am indeed a part of the 'EFT community', having other EFT practitioners and users as friends or acquaintances. Further discussion on insider research will be provided later in this chapter.

Heidegger's interpretative approach to phenomenology has been discussed previously. Heidegger pressed that it is not possible to suspend our pre-conceptions while understanding phenomena, such as people's experiences. When interpreting some phenomena, the interpretative process is bound to be based upon our fore conceptions and structures, such as previous

experiences, assumptions, preconceptions, culture, and so on (Smith et al., 2009). Heidegger concurs with Husserl that these fore-conceptions are likely to cause impediments in the understanding of a phenomenon. However, he proposes an alternate way to counter this issue, rather than 'bracketing' as Husserl suggests. For example, while engaging with data, the researcher may not be aware of his/her pre-conceptions to begin with; however, the researcher may be better placed to uncover his/her fore-structures *after* having engaged with the text (Smith et al., 2009; Biggerstaff & Thompson, 2008).

German philosopher Hans-Georg Gadamer, corroborated Heidegger's hermeneutic approach in the context of analysis of biblical and historical texts. Gadamer argued that while engaging with a text, a person is always 'projecting' (Smith et al., 2009). Gadamer suggested that while some fore-conceptions and biases may be obvious to the researcher at the start, a majority will emerge during the research process (Smith et al., 2009). Therefore, the researcher needs a degree of openness in acknowledging and questioning his/her own beliefs and biases throughout the research process.

Heidegger's interpretative phenomenological approach is a critical pillar of IPA. IPA research also involves a 'double-hermeneutic' which implies a two-fold interpretative process, firstly, the participant's meaning-making or their interpretation of their own experience; and secondly, the researcher's meaning-making or interpretation of the participant's account of their experience (Smith & Osborn, 2003).

### *Idiography*

IPA studies are generally undertaken at an idiographic level (Larkin et al., 2006). Idiography is concerned with the study of specifics. Idiographic studies usually involve examination of individual people, but can also encompass study of specific events or situations (Larkin et al., 2006).

Therefore, IPA studies require a thorough and in-depth analysis of data gathered from a relatively small number of participants (Larkin et al., 2006). IPA studies have an idiographic focus, in which the researcher must respect each participant by working rigorously with their data (Smythe, 2011). As such, IPA was considered suitable for this study which aims to explore individuals' unique experiences of the EFT therapeutic approach.

### *The Phenomenon*

Smythe (2011) stated that at the centre of a phenomenological study, is 'the phenomenon', where the phenomenon being studied is the basis of the research process and informs the "thinking, questioning, listening, reading, and writing" in the research process (Smythe, 2011, p. 39). Stating the phenomenon helps strengthen the researcher's focus and commitment to the research aim while diminishing other interesting, but out of scope diversions emergent in the data. The ultimate goal of the research study is to present an amalgamation of writing which depicts the participants' experiences of the phenomenon. For the purpose of my study, the phenomenon under study is 'experiences of EFT'. In other words, this thesis will elucidate how the study's participants experienced EFT in supporting chronic disease healthcare.

### **Positioning the researcher within the research**

#### *Insider Research*

It has been previously noted that the current study can be considered to constitute insider research. Insider research denotes research that is conducted within an organisation, community, or culture, which the researcher is a part of (Hewitt-Taylor, 2002). As a user trained in the EFT therapeutic approach, I may be considered an 'insider' in the community of EFT users. IPA acknowledges that it is not possible, or even appropriate to completely remove the researcher from the research (Larkin et al., 2006). IPA accepts that researchers' prior knowledge, life experiences and attitudes

provide context to a study's findings. For this reason, IPA is considered suitable for insider research.

Insider researchers can have various advantages, such as the ability to more easily build rapport with participants, and ease of communication given their knowledge of linguistic cues and “non-verbal cultural competence” (Hockey, 1993, p. 204) and prior knowledge of issues and opportunities in the topic area (Costley, Elliott & Gibbs, 2010). Consequently, insider research can assist a researcher to gather more in-depth data and a greater amount of contextual information. However, insider research also comes with a number of challenges (Hewitt-Taylor, 2002). For example, the familiarity with the research environment may lead to the researcher making undue assumptions about the participants' experiences based on the researcher's own knowledge or experience, thereby encumbering the data collection and analysis procedures (Greene, 2014). IPA too recognises that a researcher's insider perspective and prior knowledge can both impede and enrich the interpretation of participants' accounts (Shaw, 2010). Reflexive processes can be used to counter some challenges of insider research, as described in the following section.

### *Reflexive Processes*

I have noted earlier that engagement rather than detachment is an integral aspect of qualitative research (Hewitt-Taylor, 2002). Reflexivity is a process by which researchers evaluate and develop awareness of themselves, including their attitudes, thoughts, reactions, and habits (Clancy, 2013). According to Green and Thorogood (2013), reflexive inquiry spans two main dimensions: firstly, contemplating and understanding the research itself, including why a particular research aim must be answered, as well as its social and political context; and secondly, examining personal considerations of the researcher, such as personal experiences, gender, social status, beliefs and attitudes. The second dimension appears particularly relevant to IPA and this project.

IPA, like various other qualitative approaches, acknowledges that it is not possible or even desirable for researchers to completely bracket themselves out of their research and function as ‘objective’ data-collecting machines. Data is not simply collected; instead it is collaboratively produced by the researcher and participants (Green & Thorogood, 2014). Furthermore, by practising reflexive processes, researchers can enrich the emergent findings (Clancy, 2013).

Shaw (2010) argued that a researcher’s preconceptions and prior knowledge can either enhance the interpretative process or thwart it. Therefore, reflexive activities should not just be limited to the preparation and data collection stage; instead, they should be woven into every phase of the research process. The idea of weaving reflexive processes throughout the research process is also commensurate with the hermeneutics scholar Gadamer’s suggestion that a researcher’s preconceptions are part known and part emergent.

Reflexivity can be used to the researcher’s advantage to enrich the interpretation of people’s lived experiences (Shaw, 2010). Reflexive processes can be undertaken in various ways, such as keeping a reflexive log, revisiting data at a later stage after emotional response to a certain aspect of the participant account has receded, or seeking a fresh perspective from a person not involved in the research (Shaw, 2010). The aforementioned reflexive activities can elucidate and allow for the critical analysis of a researcher’s presuppositions along with the participants’ accounts.

For the purpose of the current study, reflexive journaling was undertaken throughout the research process. Reflexive journaling for the current study ranged from systematically documented notes, to more ad-hoc records of responses to the data (e.g. note-taking in interview transcripts). Furthermore, the interview transcripts, analytical procedures, and findings were discussed with the study supervisors throughout the research process. Additionally, a data analysis



workshop was undertaken with the supervisors to seek another perspective on the emergent data and synthesise the study's findings. Kitto, Chesters and Grbich (2008) recommended that discussion among researchers can help enhance the interpretative rigour in the study, and help broaden and refine the data analysis findings. Smith et al. (2009) also recommended the solicitation of supervisors' input in the data analysis process for PhD students or beginner researchers.

## Methods

### *Data Collection*

#### *Chosen data collection tool: Semi-structured Interviews*

Given the idiographic focus of IPA, semi-structured interviews are the most commonly used data collection tool in IPA studies (Smith & Eatough, 2007). Interviews provide a suitable means of generating rich and detailed first person accounts of participants' experiences (Smith et al., 2009; Liamputtong & Ezzy, 2005). Semi-structured interviews can allow researchers to elicit detailed yet targeted information such as participants' accounts of specific experiences. Liamputtong and Ezzy (2005) suggest that interviews are an avenue for a researcher to witness, first-hand, his/her participants making sense of their own lives.

An interview can be described as an intentional conversation (Smith et al., 2009; Liamputtong & Ezzy, 2005), where the research aim underpins this conversation. The interview questions or 'prompts' are formulated in order to enable the participants to descriptively retell their experiences in their own words. The questions are open-ended and aim to elicit extensive and detailed responses from participants. Open-ended questions allow the participants to do most of the talking in the interview. The researcher then answers the research aim through the analysis of participants' responses (Smith et al., 2009). Therefore, semi-structured interviews were considered to be a suitable means of gathering rich information on users' experiences of EFT for supporting chronic disease healthcare, and chosen as the data collection tool for this study.

## *Ethics*

Any research involving human participants conducted by Monash University researchers requires ethics clearance from the Monash University Human Research Ethics Committee (MUHREC) prior to commencement. This study was approved by MUHREC (CF14/3800 – 2014001991) as a Low Risk research project. A copy of the Ethics Clearance Certificate has been supplied in Appendix B. As part of the recruitment process, participants were provided with a detailed Explanatory Statement outlining the research, potential risks of participation, data handling procedures and confidentiality protection measures taken by the research team. Upon reading the Explanatory Statement, participants signed a consent form which included consenting to the data they provide being used for publications and future research. Data acquisition began only after participants had given informed consent using the process outlined above.

There were no major perceived risks for participants of this research, except for slight discomfort. Since the research centred on people who had already reported having some measure of recovery from their health conditions, it was unlikely that the participants would experience any significant distress while talking about their recovery journeys. Participants were advised that they could refuse to answer distressing questions, if any, without reason. Confidentiality was a primary area of concern in this research. Participants were de-identified through the use of pseudonyms. Any information that practitioners provided about clients or other third parties was also de-identified.

## *Sampling and Recruitment*

### *Sampling: Purposive*

Given the idiographic nature of the IPA methodology, most IPA studies involve purposive sampling (Smith & Osborn, 2008). In purposive sampling, researchers aim to find a well-defined homogenous group of participants for whom the research aim will be relevant (Smith & Osborn,

2008). Sample sizes are usually small, sometimes as little as five or six participants because 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 (Brocki & Wearden, 2006).

### *Inclusion and Exclusion Criteria*

For the current study, participants were divided into two groups: EFT practitioners who had provided EFT treatment to chronic disease patients, and chronic disease patients who had used EFT to support their healthcare. The inclusion and exclusion criteria established for the study participants are outlined as follows.

#### *Group 1: EFT Practitioners*

The following inclusion criteria were established to ensure that the practitioners recruited for this study were sufficiently skilled and experienced in using EFT to assist chronic disease patients by:

- being trained through an established professional body such as Association for the Advancement of Meridian Energy Techniques (AAMET), EFT Universe, or Association for Comprehensive Energy Psychology (ACEP);
- having a minimum four years' experience practising EFT professionally; and
- having worked with at least three adults with chronic diseases.

It should be noted because EFT is a generic modality that can be applied widely many different conditions ranging from test anxiety, to sports performance, to chronic illness, most practitioners do not specialize in a specific chronic illness, or even generally for chronic illnesses. As such, while the requirement for practitioners having worked with three chronic illness patients may appear a relatively low number, it was chosen to allow the researcher to gather a large enough practitioner participant sample size. Additionally, the requirement for five years' professional experience was also set to such that only sufficiently experienced practitioners would be included in the study.

## Group 2: Chronic Disease Patients

The participants of this group included adults with physical chronic diseases who had used EFT as part of their chronic disease healthcare regimes either by self-application or via practitioner-support, or a combination of both.

## Other Exclusion Criteria

In addition to the inclusion criteria mentioned above, the following exclusion criteria for both participant groups were also established, to minimise research or ethics related risks:

- children under the age of 18;
- pregnant women;
- people under palliative care; and
- people with cognitive impairments, medically diagnosed mental illnesses or intellectual disabilities.

## *Participant Recruitment*

Advertisements soliciting practitioners and patients to participate in the study were published in e-newsletters and social media avenues of professional bodies and EFT interest groups such as AAMET, EFT Universe, ACEP and EFT Australian Practitioners Association (EFTAP). Some practitioners were also requested to advertise this research among clients within their practices. Interested people contacted the researcher via email to express interest in participating. They were then asked screening questions about their professional experience and qualifications (in the case of practitioners); or their health condition and EFT utilisation (in the case of patients) via telephone or email. If they satisfied the inclusion/exclusion criteria outlined above and gave informed consent using the procedure outlined in the ethics processes, they were included (or waitlisted for inclusion) in the study. In addition to the above, certain practitioners were directly invited by the researcher to participate in the research through their publically available contact

details obtained from their business websites. The consent process included reading an Explanatory Statement and signing a Consent Form, both of which had been approved as part of the Ethics Application.

### *How the interviews were conducted*

Building rapport with the participant is important to gather good quality relevant data (Smith et al., 2009; Yow, 2005). Unless the participant feels comfortable talking to the researcher, they may feel reluctant to freely share their experiences, which may make the interview process challenging. In order to ensure that the participants were comfortable during the interview, the following steps were undertaken at the start of the interviews:

- I thanked them for taking the time to undertake the interview and expressed appreciation at their willingness to share their personal information and experiences.
- I reassured the participants that they did not have to feel obligated to answer any questions they were not comfortable answering.
- I reiterated that any information they provided would be anonymous and completely de-identified.
- I gave them an opportunity to ask any questions that they might have prior the commencement of the interview.
- I requested the participants to freely share any information that came to mind, without questioning its relevance, and stated that any extra information could be easily excluded from the analysis at a later stage, and sometimes seemingly irrelevant information may prove useful in the analysis at a later stage.

The interviews typically took between 60 – 75 minutes, with some lasting up to 90 minutes. The interviews were structured such that questions pertaining to different research objectives were placed together. Common demographic information was collected from both practitioner and patient participants including age, gender, location and occupation. An indicative interview guide for both the practitioner and patient participants is provided below. Given the nature of semi-structured interviews, the questions further evolved as the interview conversations progressed.

### *Interview Guide: EFT Practitioners*

1. Can you tell me a little bit about yourself? (Ice-breaker question requesting general introduction about the participant)
2. How did you decide to become an EFT practitioner?
3. Can you share some examples of cases where you have provided EFT therapy to people with chronic diseases? (Further probing was undertaken to gain details about each client case example, such as illness symptoms, extent/length of EFT treatment, specificities about issues addressed during the EFT treatment {e.g. long-standing negative beliefs, traumas etc.}, perceptions about results achieved)
4. Why do you think EFT works? (Practitioners' perception of the mechanism of action in EFT)
5. Why do you think EFT can be applied to a range of different conditions or issues?
6. Do you administer EFT via telephone and/or online mediums? If so, what has your experience been like?
7. Do you recommend your clients to self-administer EFT for self-care? If so, what is your recommended self-care approach to clients?
8. Final thoughts and opportunity to provide any additional information.

### *Interview Guide: Chronic disease patients*

1. Can you tell me a little bit about yourself? (Ice-breaker question requesting general introduction about the participant)
2. Can you tell me a bit about your illness, e.g. when it started, symptoms, and effects on your life?
3. How were you introduced to EFT, and why did you decide to try it?

4. Can you tell me a little about your EFT treatment regime (e.g. length of treatment; self-administered or practitioner-led)
5. Can you give me some examples of the issues you may have addressed in your EFT sessions?
6. What has your experience of EFT been like?
7. What does recovery mean to you personally?
8. Why do you think EFT works? (Patients' perceptions of the mechanism of action in EFT)
9. Have you received EFT therapy via telephone or online mediums? What has your experience been like?
10. Do you use EFT for self-care? If so what is your usual EFT self-care regime?
11. Final thoughts and opportunity to provide any additional information.

### *Participants*

Sixteen participants, including eight EFT practitioners and eight chronic disease patients were recruited for this study. Participant information is provided in Tables 3.1 and 3.2. Table 3.1 presents an overview of practitioner participants' demographic information, professional status and experience. Table 3.2 provides an overview of patient participants' demographic information, health condition, and EFT utilisation.

### *Member checking*

Member checking is often adopted as a means to ensure validity in certain qualitative traditions. The current study used the IPA research methodology, which is grounded in an interpretive paradigm. Within this paradigm, unlike realist or essentialist paradigms, reality is considered to be multiple and constructed (Sandelowski, 1993). The focus of an interpretive paradigm is not to discover a single tangible reality, rather to construct an understanding of a contextual reality (Sandelowski, 1993). Sandelowski (1993) argued that tools such as member checking to reach a singular, repeatable response from participants pose a threat to validity in phenomenological research. Therefore, for the purpose of the current study, member verification was limited to the

participants' demographic data and professional qualifications/certifications related information (in the case of practitioners), and EFT utilisation (in the case of patients). This verification was conducted via email upon the completion of the interviews, as needed.



**Table 3.1: Participant Information: EFT Practitioners**

Participant pseudonym	Age	Country of Residence	Gender	Years of Professional EFT Experience	Professional Status	Examples of chronic illnesses dealt with in practice
<b>Abigail</b>	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)
<b>Donna</b>	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
<b>Frank</b>	26	Australia	Male	4 years	- AAMET trained EFT Practitioner	Lyme's Disease, Vaginal Infection, Chronic Pain
<b>Iris</b>	33	England	Female	8 years	- AAMET Accredited EFT Practitioner - AAMET Accredited EFT Trainer - AAMET Accredited EFT Supervisor	CFS, Fibromyalgia, Multiple Chemical Sensitivity
<b>Madeleine</b>	62	Spain	Female	12 years	- AAMET Accredited EFT Practitioner - AAMET Accredited Trainer of Trainers - AAMET Accredited EFT supervisor	Multiple Sclerosis, Cancer, Chronic Pain
<b>Rachel</b>	43	Australia	Female	10 years	AAMET trained EFT Practitioner	CFS, Migraines, Chronic Pain, Rheumatoid Arthritis, Ulcerative Colitis, Diabetes
<b>Samantha</b>	47	Australia	Female	9 years	- AAMET Accredited EFT Practitioner	Chronic Pain, Cancer, Arthritis

Participant pseudonym	Age	Country of Residence	Gender	Years of Professional EFT Experience	Professional Status	Examples of chronic illnesses dealt with in practice
					- AAMET Accredited EFT Trainer	
<b>Taylor</b>	44	England	Non-binary	6 years	AAMET Accredited EFT Practitioner	Fibromyalgia, CFS, Hailey Hailey, Chronic Pain, Irritable Bowel Syndrome

**Table 3.2: Participant Information: Chronic Disease Patients**

Participant pseudonym	Age	Country of Residence	Gender	Health condition	Overview of EFT utilisation
<b>Alicia</b>	53	Australia	Female	Mast Cell Activation Disorder and Chronic Fatigue Syndrome	Self-administered, With practitioner (primarily online therapy)
<b>Candace</b>	56	Australia	Female	Fibromyalgia and migraines	Primarily self-administered
<b>Cassandra</b>	65	USA	Female	Chronic Fatigue Syndrome and Fibromyalgia	Self-administered, With practitioner
<b>Daisy</b>	46	England	Female	Chronic Fatigue Syndrome	Self-administered, With practitioner
<b>Faith</b>	36	Scotland	Female	Chronic Fatigue Syndrome	Self-administered, With practitioner
<b>Hannah</b>	57	Canada	Female	Crohn's Disease	Primarily self-administered
<b>Kayley</b>	23	England	Female	Chronic Fatigue Syndrome	Self-administered, With practitioner (primarily online therapy)
<b>Rhea</b>	55	Australia	Female	Arthritis	Self-administered, With practitioner

## *Data Analysis*

### *Transcription*

Interviews were transcribed verbatim, as required by the IPA methodology (Smith et al., 2009). Non-verbal expressions such as laughter, long pauses, hesitation, or other emotional reactions were also recorded in the transcripts as these can yield valuable information about the participants' accounts and assist in the interpretative process (Smith et al., 2009). The transcripts were formatted with wide page margins which allowed me to make extensive comments and notes during data analysis and throughout the research process (Smith et al., 2009).

### *The IPA Process*

The overarching data analysis process undertaken for the current study can be conceptualised in the form of a three-fold progression. Preliminary data analysis was undertaken following the completion of data collection, whereby memos were created during data collection and first level analysis was completed, resulting in the emergence of a range of themes. Second level analysis involved analysis activities undertaken during interview transcription. The final deeper level of data analysis was undertaken using the verbatim interview transcripts. While these steps may appear chronological, each of these steps often occurred concurrently, and were also informed by each other. Further details of the IPA data analysis process as adopted for the current study are provided below.

#### *Step 1: Revisiting the data*

The first step of the data analysis process involved revisiting the data; including looking at interview notes after the completion of an interview, listening to interview recordings, transcribing, or reading the interview transcripts. The data was revisited to get a general sense of the interview, and potentially identifying an overarching theme of the interview (Storey, 2007). Any contradictions or fragmented information provided in the data was also identified and noted.

## Step 2: Initial Noting

The initial note-taking step involved making detailed comments and notes on the data. This step involved freely capturing any points of interest and undertaking exploratory note-taking and commentary (Smith et al., 2009; Storey, 2007). The exploratory comments fell under one of the following three categories (Smith et al., 2009):

- **Descriptive Comments:** Focusing on the participants' interview responses (content of the interview)
- **Linguistic Comments:** Focusing on the participants' use of language
- **Conceptual Comments:** Focusing on working with the data at a deeper probing and conceptual level

Initial noting was an iterative, non-exhaustive process. In relation to this initial noting step, Smith et al. (2009) suggested that as a researcher works through the data, he/she will be likely to make comments on both the similarities and differences, extensions and inconsistencies or paradoxes in what the participant has said. This step required getting involved with each line of the interview transcripts on an analytical level, questioning what each word, phrase, or sentence meant to me, and what it may have meant for the participant, as per the constructivist epistemology.

## Step 3: Developing Emergent Themes

The third step comprised an analytical process that involved closely looking at the exploratory notes and combining them into emergent themes. This step can be thought of as rearranging or restructuring the data (Smith et al., 2009; Storey, 2007) into smaller manageable pieces. The exploratory notes from the previous step were turned into themes which reflected both the participants' descriptions and the researcher's interpretation (Smith et al., 2009). This step also required a shift in focus from the actual data to the notes developed in the previous step.

#### Step 4: Searching for connections across emergent themes

Step 4 involved organising and grouping the themes to formulate a structure. This process was open-ended, but informed by the research aim and scope, as well as the epistemological, theoretical and methodological assumptions underpinning the study. In order to form connections between themes and cluster them together, several different approaches were employed (Smith et al., 2009, p. 96-97). :

- **Abstraction:** This process involved finding similar themes and grouping them together into an overarching theme, often referred to as a ‘super-ordinate theme’.
- **Polarisation:** In polarisation, themes were clustered based on their opposing or contradictory relationships (Smith et al., 2009), rather than their similarities.
- **Contextualisation:** This approach involved identification of background or descriptive aspects within the data. For example, these themes related to the participant’s key life events often organised in a temporal fashion (Smith et al., 2009).
- **Numeration:** The frequency of occurrence of a certain theme was also a useful (but not the only) indicator of the relative importance of that theme for the participant.

#### Step 5: Moving to the Next Case

After one piece of data (e.g. a participant’s interview transcript) had been analysed using the steps outlined above, the researcher moved to the next piece, and treated it as a stand-alone case. In light of IPA’s idiographic focus, it was important to allow new themes to emerge, without letting the previous analyses put any limitations on the current analysis. Application of reflexive processes and rigorously following the IPA data analysis methodology helped minimise the above risk.

## Step 6: Looking for patterns across cases

The final stage in the data analysis process involved cross-analysis of the different cases to identify connections between the various cases and emergent themes within them. This exercise also involved re-structuring and renaming of themes (Smith et al., 2009). Given that two perspectives were used in this study, the data provided by practitioner and patient participants was first analysed separately for the respective participant groups. Subsequently, cross-analysis of findings emerging from practitioner data and patient data, was also undertaken.

The aforementioned IPA data analysis process resulted in the synthesis of four overarching super-ordinate themes, each of which relate to one of the study's research objectives. Each of these four overarching themes have been explored in separate results chapters, and is informed by patients' and/or practitioners' perspectives in alignment with the research objectives. The four overarching themes which are explored in their corresponding results chapters are outlined in Table 3.3, and broadly encompass:

- EFT as a practice for supporting chronic disease healthcare;
- patients' meanings of chronic disease;
- patients' constructions of recovery; and
- evaluation of EFT using WHO Determinants of Health.

An overview of the four results chapters including their constituent themes, corresponding research objectives, participant perspectives used to inform the findings, and format of the results chapter, is provided in Table 3.3. These findings are presented in Chapters 4 – 7. It should be noted that Chapters 4, 5 and 7 comprise journal articles published or under review in peer reviewed academic journals. Chapter 6, that explores the notion of recovery however, has been presented as an unpublished thesis chapter, because its length (almost 10,000 words of the findings section alone) was outside most journals' prescribed word limits. It should also be noted that there may

be some apparent repetition of theoretical and methodological concepts across the three journal articles. However, sufficient exposition was necessary for assisting readers of the standalone journal articles who may not necessarily have the context of this complete thesis document. Finally, a discussion of the emergent findings and concluding remarks are provided in Chapter 8.

Table 3.3: Overview of Research Findings

No.	Overarching theme / Results chapter	Themes presented	Corresponding research objective / Chapter description	Perspectives used	Format
1	<b>EFT as a practice for supporting chronic disease healthcare</b>	<ul style="list-style-type: none"> <li>- One technique, many emotions</li> <li>- Tapping on the physical</li> </ul>	Explores EFT practitioners' perceptions and experiences of using EFT to support chronic disease healthcare.	EFT practitioners	Journal article – Published (Journal: <i>Disability &amp; Rehabilitation</i> )
2	<b>Patients' meanings of chronic disease</b>	<ul style="list-style-type: none"> <li>- Disease as an embodiment of unresolved emotional issues</li> <li>- Disease as a call for 'time-out' and attention</li> <li>- Disease as a boundary from other people</li> </ul>	Explores chronic disease patients' personal symbolic meanings of their illnesses as emergent from their experience of EFT therapy.	Chronic disease patients	Journal article – Under review (Journal: <i>Disability &amp; Rehabilitation</i> )
3	<b>Patients' constructions of recovery</b>	<p><u>Constructions of the Recovery Journey:</u></p> <ul style="list-style-type: none"> <li>- Opening up to the possibility of recovery</li> <li>- The Spiral Path to Recovery</li> <li>- Creating a new me</li> </ul> <p><u>Markers of Recovery:</u></p> <ul style="list-style-type: none"> <li>- Improved emotional state</li> <li>- No longer restricted by illness</li> <li>- Moving beyond survival</li> </ul>	Explores chronic disease patients' personal notions of recovery from their illnesses.	Chronic disease patients	Thesis chapter
4	<b>Evaluation of EFT using WHO Determinants of Health</b>	<ul style="list-style-type: none"> <li>- Experiences of online EFT therapy</li> <li>- Experiences of telephone delivery of EFT</li> <li>- Online communities of support</li> <li>- EFT for self-care</li> </ul>	Explores patients' and practitioners' experiences of telephone/internet delivered, and self-administered EFT in the context of the WHO determinants of health.	EFT practitioners, chronic disease patients	Journal article - Published (Journal: <i>Energy Psychology</i> )



## Chapter Summary

This chapter presented the theoretical orientation, methodological framework, and participant information for this study. This is a qualitative study based on a constructivist epistemological position, assuming a symbolic interactionist theoretical perspective. Interpretative Phenomenological Analysis was chosen as the study methodology. Information on data collection tools, ethical considerations, and the data analysis process was also provided. Eight chronic disease patients and eight EFT practitioners were interviewed for this study. Chapters 4 - 7 present the emergent findings, with each chapter exploring a research objective. Chapter 8 provides a synthesis of the study's findings in light of the current research and practice, and concludes the thesis. The next chapter forms the first results chapter of this thesis and presents emergent findings in relation to EFT practitioners' experiences of using EFT to support chronic disease healthcare.

# Chapter 4: Emotional Freedom Techniques (EFT) as a practice for supporting chronic disease healthcare: A practitioners' perspective

---

## Introduction

Having outlined the theoretical and methodological framework for this study, the emergent findings from my research project will now be presented. Chapter 4 is the first results chapter of this thesis. This chapter presents emergent findings in relation to the first research objective, to explore:

*EFT practitioners' perceptions and experiences of using EFT to support chronic disease patients.*

This chapter is informed by the interviews of the eight practitioner participants. This chapter comprises a journal article whose reference is provided below. Due to the requirements of the journal, this chapter is presented in third person voice. Two emergent themes are explored in this chapter: 'One technique, many emotions', and 'Tapping on the physical'.

## Chapter Contents: Journal article

This chapter comprises the following journal article:

Kalla, M., Simmons, M., Robinson, A., & Stapleton, P. (2017). Emotional Freedom Techniques (EFT) as a practice for supporting chronic disease healthcare: A Practitioners' Perspective. *Disability and Rehabilitation*, Online First Publication. doi: 10.1080/09638288.2017.1306125.

A copy of the aforementioned journal article is included in the thesis as follows. I have not renumbered the pages of the journal article with the view to include the publication in its original form.



## Emotional freedom techniques (EFT) as a practice for supporting chronic disease healthcare: a practitioners' perspective

Mahima Kalla, Margaret Simmons, Anske Robinson & Peta Stapleton

To cite this article: Mahima Kalla, Margaret Simmons, Anske Robinson & Peta Stapleton (2017): Emotional freedom techniques (EFT) as a practice for supporting chronic disease healthcare: a practitioners' perspective, Disability and Rehabilitation

To link to this article: <http://dx.doi.org/10.1080/09638288.2017.1306125>



Published online: 27 Mar 2017.



Submit your article to this journal [↗](#)



View related articles [↗](#)



View Crossmark data [↗](#)

ORIGINAL ARTICLE



## Emotional freedom techniques (EFT) as a practice for supporting chronic disease healthcare: a practitioners' perspective

Mahima Kalla<sup>a</sup>, Margaret Simmons<sup>a</sup>, Anske Robinson<sup>a</sup> and Peta Stapleton<sup>b</sup>

<sup>a</sup>School of Rural Health, Monash University, Melbourne, Australia; <sup>b</sup>Faculty of Society & Design, Bond University, Gold Coast, Australia

### 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 analyzed using Interpretative Phenomenological Analysis methodology.

**Results and conclusion:** This article presents 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-centered healthcare approach. EFT offers potential as a technique that may be used by health practitioners to support the psychosocial aspect of chronic disease healthcare.

### ARTICLE HISTORY

Received 21 November 2016  
Revised 9 March 2017  
Accepted 9 March 2017

### KEYWORDS

Emotional freedom techniques; chronic disease; interpretative phenomenological analysis; emotions; biopsychosocial model

### ► IMPLICATIONS FOR REHABILITATION

- Rehabilitation professionals should incorporate suitable psychological interventions (e.g., EFT) to improve coping and acceptance in physical chronic disease patients and alleviate their fears about the future.
- Rehabilitation professionals are also recommended to address in chronic disease patients, long-standing or unresolved emotional issues, including past traumas from early life, using EFT or another suitable intervention.
- Rehabilitation professionals should help improve patients' emotional states using EFT to enhance physical symptom management.

## Introduction

For most of the twentieth 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 focuses 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 [10] argue that the above recovery

model is also applicable to chronic physical illnesses. Harvey and Ismail [10] suggest that psychiatric problems interact with physical health conditions, and thus providing psychological support is crucial for effective management of physical health conditions.

A contemporary psychotherapeutic intervention, called 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 [11–14].

### **Emotional freedom techniques**

EFT, also known as “Tapping” is a therapeutic tool, which combines principles of Western psychotherapy with Chinese acupuncture. Craig and Fowlie [15] and subsequently Church [16] have described the process of EFT. 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), or object of phobia [17]. The subject self-reports an initial perceived distress rating, also known as a “subjective unit of distress” (SUD) score on a scale of 0–10, 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 [18–20]. 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 [22] suggest that EFT has potential effects on the body's physiological systems that regulate stress, emotional intensity, and associated neural transmission frequencies. Stapleton et al. [23] indicate that EFT appears to decrease activity in the amygdala, leading to calming of the “fight, flight, freeze” threat response to emotional triggers. Brattberg [24] further suggests that similar to Cognitive Behavioral Therapy and Mindfulness, EFT relies on the premise that acceptance of, rather than resistance to, a particular condition can reduce suffering.

### **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 [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 [27] 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. Bohart [26] 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. According to Bohart [26], the therapist is a facilitator for the client, and therapeutic process is best focused on collaboration and dialog.

In the EFT approach, the therapeutic process is usually guided by the client's emotion 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 endeavoring 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 conceptualization 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 recognizes 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 practicing 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 generalizability 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 practicing 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.

### **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 and 120 min, with average time being about 80 min. 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



Table 1. Participant information.

Participant pseudonym	Age	Country of residence	Gender	Years of professional EFT experience	Professional status	Examples of chronic illnesses dealt with in practice
Abigail	43	Canada	Female	12 years	<ul style="list-style-type: none"> <li>• AAMET-accredited EFT practitioner</li> <li>• AAMET-accredited EFT trainer</li> <li>• Canada AAMET representative</li> </ul>	CFS, fibromyalgia, arthritis, multiple sclerosis, crohn's disease, ulcerative colitis, irritable bowel syndrome, diabetes, Lou Gehrig's (ALS)
Donna	55	Mexico	Female	12 years	<ul style="list-style-type: none"> <li>• AAMET-trained EFT practitioner</li> <li>• AHEFT-certified EFT trainer (Spanish association for EFT trainers)</li> </ul>	Fibromyalgia, gastritis, colitis, frozen shoulder, sciatic nerve pain, chronic pain, high blood pressure, cancer, diabetes
Frank	26	Australia	Male	4 years	<ul style="list-style-type: none"> <li>• AAMET-trained EFT practitioner</li> </ul>	Lyme's disease, vaginal infection, chronic pain
Iris	33	England	Female	8 years	<ul style="list-style-type: none"> <li>• AAMET-accredited EFT practitioner</li> <li>• AAMET-accredited EFT trainer</li> <li>• AAMET-accredited EFT supervisor</li> </ul>	CFS, fibromyalgia Multiple chemical sensitivity
Madeleine	62	Spain	Female	12 years	<ul style="list-style-type: none"> <li>• AAMET-accredited EFT practitioner</li> <li>• AAMET-accredited trainer of trainers</li> <li>• AAMET-accredited EFT supervisor</li> </ul>	Multiple sclerosis, cancer Chronic pain
Rachel	43	Australia	Female	10 years	<ul style="list-style-type: none"> <li>• AAMET-trained EFT practitioner</li> </ul>	CFS, migraines, chronic pain, rheumatoid arthritis, ulcerative colitis, diabetes
Samantha	47	Australia	Female	9 years	<ul style="list-style-type: none"> <li>• AAMET-accredited EFT practitioner</li> <li>• AAMET-accredited EFT trainer</li> </ul>	Chronic pain, cancer, arthritis
Taylor	44	England	Non-binary	6 years	<ul style="list-style-type: none"> <li>• AAMET-accredited EFT practitioner</li> </ul>	Fibromyalgia, CFS, Hailey Hailey, chronic pain, irritable bowel syndrome

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. [31] was employed for this study. A brief overview of the data analysis process is outlined as follows:

*Revisiting the data:* This included review of interview notes, listening to an interview recording, and reading of an interview transcript.

*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.

*Synthesizing 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".

*Grouping and organizing emerging themes to structure data:* Themes were organized based on their similarities, differences, and contextual settings. This step was underpinned by the research question and scope.

*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.

*Looking for patterns across cases:* Once all the interview transcripts had been analyzed 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 coauthors to further enhance the interpretative rigor of the data analysis process, and synthesize the emergent themes.

Brocki and Wearden [34] highlight the importance of employing reflexive procedures in IPA. 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 coauthors 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 an interpretive paradigm is not to discover a single, tangible reality, rather to construct an understanding of a contextual reality [42]. Sandelowski [42] argues that tools such as member-checking to reach a singular, repeatable response from participants, in fact, poses threat to validity in phenomenological research. 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 disease, 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 behavioral 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 behavior 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 traumatizing 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 h 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 sensitized. 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 [7]. Taylor uses EFT to assist this client come to terms with the most pressing issues at hand, such as inability to fulfill 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 instill 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, first, 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 realize 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 behavior 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 behavioral 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 fulfill their societal and economic roles, when suffering from chronic diseases. Stanton, Revenson and Tennen [44] argue that chronic diseases have crucial social and psychological implications which necessitate considerable psychological adjustment. Indeed “acceptance” is the precursor to adjustment [45]. McCracken et al. [46] 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. 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 [24] indicates that EFT relies on the premise that acceptance of, rather than resistance to a particular circumstance or condition, can reduce suffering.

Participants illustrated their use of EFT for addressing patients’ meanings and perceptions of themselves, and their illnesses. Scharloo et al. [47] 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 behavior, and ultimately, on the patient’s physical health and well-being.

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 et al. [48] 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.

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. [49 p. 937] suggest that “pain-eliciting and pain-aggravating thoughts” impact illness behavior. In addition, Heinrich et al. [49] highlight the importance of monitoring maladaptive thoughts, feelings, and behavior to improve coping abilities with physical symptoms.

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 et al. [50] also argue that behavioral interventions can be useful for alleviating side-effects of invasive biomedical treatments, such as anticipatory nausea, vomiting, anxiety, and pain.

### *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-centered healthcare approach, underpinned by the biopsychosocial model of health. A patient-centered 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. Second, 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. Third, 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 generalized patient well-being only, and not disease-specific healthcare.

## Conclusions

Chronic disease patients may benefit from a holistic healthcare approach that adopts a patient-centered 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.

## Acknowledgements

The authors thank all participants of this study.

## Disclosure statement

Authors report no conflicts of interest.

## References

- [1] Engel G. The need for a new medical model: a challenge for biomedicine. *Science*. 1977;196:129–136.
- [2] Sperry L. Psychological treatment of chronic illness: the biopsychosocial therapy approach. Washington (DC): American Psychological Association; 2006.
- [3] Hamilton-West K. Psychobiological Processes in Health and Illness. London: Sage Publications Limited; 2011.
- [4] Slade M, Amering M, Farkas M, et al. Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*. 2014;13:12–20.
- [5] Webb L. The recovery model and complex health needs: What health psychology can learn from mental health and substance misuse service provision. *J Health Psychol*. 2012;17:731–741.
- [6] Whitley R, Drake R. Recovery: a dimensional approach. *Psychiatric Serv*. 2010;61:1248–1250.
- [7] Walker C. Ruptured Identities: leaving work because of chronic illness. *Int J Health Serv*. 2010;40:629–643.
- [8] Anthony WA. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosoc Rehabil J*. 1993;16:11–23.
- [9] Liberman R, Kopelowicz A. Recovery from schizophrenia: a concept in search of research. *Psychiatr Serv*. 2005;56:735–742.
- [10] Harvey S, Ismail K. Psychiatric aspects of chronic physical disease. *Psychiatric Aspects Gen Med*. 2008;36:471–474.
- [11] Bougea AM, Spandideas N, Alexopoulos EC, et al. Effect of the Emotional Freedom Technique on perceived stress, quality of life, and cortisol salivary levels in tension-type headache sufferers: a randomized controlled trial. *Explore: J Sci Heal*. 2013;9:91–99.
- [12] Church D, Palmer-Hoffman J. TBI symptoms improve after PTSD remediation with Emotional Freedom Techniques. *Traumatology*. 2014;20:172–181. Retrieved from <http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=2014-20843-001>
- [13] Ortner N, Palmer-Hoffman J, Clond MA. Effects of Emotional Freedom Techniques (EFT) on the reduction of chronic pain in adults: a pilot study. *EPJ*. 2014;6:14–21.
- [14] Hodge PM, Jurgens CY. A pilot study of the effects of Emotional Freedom Techniques in psoriasis. *EPJ*. 2011;3:13–24.
- [15] Craig G, Fowlie A. Emotional freedom techniques: the manual. Sea Ranch (CA): Gary Craig; 1995.
- [16] Church D. The EFT manual, 3rd ed. Santa Rosa (CA): Energy Psychology Press; 2013.
- [17] Boath E, Stewart A, Carryer A. A narrative systematic review of the effectiveness of Emotional Freedom Techniques (EFT). Staffordshire University, CPSI Monograph, Centre for Practice and Service Improvement; 2012. Retrieved from [https://www.staffs.ac.uk/assets/A\\_narrative\\_systematic%20Review\\_of\\_the\\_effectiveness\\_of\\_Emotional\\_Freedoms\\_Technique\\_\(EFT\)\\_tcm44-45500.pdf](https://www.staffs.ac.uk/assets/A_narrative_systematic%20Review_of_the_effectiveness_of_Emotional_Freedoms_Technique_(EFT)_tcm44-45500.pdf)
- [18] Clond M. Emotional Freedom Techniques for anxiety: a systematic review with meta-analysis. *J Nerv Ment Dis*. 2016;204:388–395.
- [19] Nelms J, Castel D. A systematic review and meta-analysis of randomized and non-randomized trials of Emotional Freedom Techniques (EFT) for the treatment of depression. *Explore: J Sci Heal*. 2016;2:416–426.
- [20] Sebastian B, Nelms J. Emotional Freedom Techniques (EFT) for posttraumatic stress disorder: a systematic review and meta-analysis. *Explore: J Sci Heal*. 2016;13:16–25.
- [21] Stapleton P, Sheldon T, Porter B. Clinical benefits of emotional freedom techniques on food cravings at 12-months follow-up: a randomised controlled trial. *Energy Psychol: Theory Res Treatment* 2012;4:1–12. Retrieved from [http://www98.griffith.edu.au/dspace/bitstream/handle/10072/49453/81989\\_1.pdf?sequence=1](http://www98.griffith.edu.au/dspace/bitstream/handle/10072/49453/81989_1.pdf?sequence=1)
- [22] Diepold JH, Goldstein D. Thought Field Therapy and qEEG changes in the treatment of trauma: a case study. *Traumatology*. 2008;15:85–93.
- [23] Stapleton P, Sheldon T, Porter B. Practical application of emotional freedom techniques for food cravings. *Int J Heal Caring* 2012;12:1–9. Retrieved from [http://www98.griffith.edu.au/dspace/bitstream/handle/10072/52756/82986\\_1.pdf?sequence=1](http://www98.griffith.edu.au/dspace/bitstream/handle/10072/52756/82986_1.pdf?sequence=1)
- [24] Brattberg G. Self-administered EFT (Emotional Freedom Techniques) in individuals with fibromyalgia: a randomized trial. *Integrative Med*. 2008;7:30–35. Retrieved from [http://www.varkstaden.se/pdf\\_filer/EFT\\_article.pdf](http://www.varkstaden.se/pdf_filer/EFT_article.pdf)
- [25] Kalla M. Supporting chronic disease healthcare through remote emotional freedom techniques (EFT) treatment and self-care: an evaluation using the WHO determinants of health. *Energy Psychol: Theory Res. Method*. 2016;8:55–66.
- [26] Bohart A. The client is the most important common factor: clients' self-healing capacities and psychotherapy. *J Psychotherapy Integr*. 2000;10:127–149.
- [27] Grencavage LM, Norcross JC. Where are the commonalities among the therapeutic common factors? *Profession Psychol: Res Pract*. 1990;21:372–278.
- [28] Church D, Marohn S, editors. The clinical EFT handbook: a definitive resource for practitioners, scholars, clinicians and researchers. Santa Rosa (CA): Energy Psychology Press; 2013.
- [29] Guest G, Namey E, Mitchell M. Collecting qualitative data: a field manual for applied research. London: Sage Publications Limited; 2013.

- [30] Crotty M. The foundations of social research: meaning and perspective in the research process. London: SAGE Publications Ltd; 1998.
- [31] Smith J, Flowers P, Larkin M. Interpretative phenomenological analysis: theory, method and research. London: SAGE Publications Ltd; 2009.
- [32] Smith J. Interpretative phenomenological analysis: a reply to Amedeo Giorgi. *Exist Anal*. 2010;21:186–192. Retrieved from <http://psycnet.apa.org/psycinfo/2010-15570-001>
- [33] Smith J, Osborn M. Interpretative phenomenological analysis. In: Smith J, editor, *Qualitative psychology: a practical guide to research methods*, 2nd ed. London: SAGE Publications Limited; 2008; pp. 53–80.
- [34] Brocki J, Wearden A. A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychol Health*. 2006;21:87–108.
- [35] Biggerstaff D, Thompson A. Interpretative phenomenological analysis (IPA): a qualitative methodology of choice in healthcare research. *Qual Res Psychol*. 2008;5:214–224.
- [36] Larkin M, Watts S, Clifton E. Giving voice and making sense in interpretative phenomenological analysis. *Qual Res Psychol*. 2006;3:102–120.
- [37] Hockey J. Research methods – researching peers and familiar settings. *Res Papers Educ*. 1993;8:199–225.
- [38] Costley C, Elliott G, Gibbs P. Key concepts for the insider-researcher. In: *Doing work based research approaches to enquiry for insider-researchers*. London: SAGE Publications Ltd; 2010. Retrieved from: [http://www.sagepub.com/upm-data/32890\\_Costley\\_Chap1.pdf](http://www.sagepub.com/upm-data/32890_Costley_Chap1.pdf)
- [39] Shaw R. Embedding reflexivity within experiential qualitative psychology. *Qual Res Psychol*. 2010;7:233–243.
- [40] Smith J, Eatough V. Interpretative phenomenological analysis. In: Evanthia L, Adrian C, editors, *Analysing qualitative data in psychology*. London: SAGE Publications Ltd; 2007. p. 35–51.
- [41] Liamputtong P, Ezzy D. *Qualitative research methods*. South Melbourne: Oxford University Press; 2009.
- [42] Sandelowski M. Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *ANS Adv Nurs Sci*. 1993;16:1–8.
- [43] Young J, Klosko J, Weishaar M. *Schema therapy: a practitioner's guide*. New York (NY): Guilford Press; 2003.
- [44] Stanton A, Revenson T, Tennen H. Health psychology: psychological adjustment to chronic disease. *Annu Rev Psychol*. 2007;58:565–592.
- [45] Taylor S. Adjustment to threatening events: a theory of cognitive adaptation. *Am Psychol*. 1983;38:1161–1173. Retrieved from 10.1037/0003-066X.38.11.1161
- [46] McCracken L, Carson J, Eccleston C, et al. Acceptance and change in the context of chronic pain. *Pain*. 2004;109:4–7.
- [47] Scharloo M, Kaptein A, Weinman J, et al. Illness perceptions, coping and functioning in patients with rheumatoid arthritis, chronic obstructive pulmonary disease and psoriasis. *J Psychosom Res*. 1998;44:573–585.
- [48] Taylor S, Kemeny M, Reed G, et al. Psychological resources, positive illusions, and health. *Am Psychol*. 2000;55:99–109.
- [49] Heinrich M, Monstadt D, Michel C. Psychologische Interventionen in der Behandlung chronischer Rückenschmerzen. *Der Orthopäde* 2009;38:937–942.
- [50] Redd W, Montgomery G, Duhamel K. Behavioral intervention for cancer treatment side effects. *J Natl Cancer Inst*. 2001;93:810–823.
- [51] Stewart M. Towards a global definition of patient centred care – the patient should be the judge of patient centred care. *Brit Med J*. 2001;322:444–445.

## Chapter Summary

This first results chapter addressed my first research objective, and presented EFT practitioners' experiences of using EFT to support chronic disease healthcare. This chapter which comprised a journal article, drew data from interviews of practitioner participants only. Two themes were presented, namely, 'One technique, many emotions', and 'Tapping on the physical'. Findings presented in this chapter suggest that chronic disease patients may benefit from a 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. The next chapter (Chapter 5) will explore chronic disease patients' personal symbolic meanings of their illnesses, as emergent from their use of EFT therapy.

# Chapter 5: Making sense of chronic disease using Emotional Freedom Techniques (EFT): An existential view of illness

---

## Introduction

The previous chapter drew from practitioners' interviews and addressed the first research objective by presenting findings in relation to practitioners' experiences of using EFT to support chronic disease healthcare. The current chapter draws from patient participants' interviews. This chapter, which is underpinned by the concepts of 'symbolic disease' and 'personhood' as discussed in Chapter 2, presents findings in relation to the second research objective, to explore:

*Chronic disease patients' personal symbolic meanings of their illnesses as emergent from their experience of EFT therapy.*

Symbolic Disease represents a phenomenon wherein the pathology of a disease appears to express the same story and meaning as the patient's personal subjective story. This chapter explores chronic disease patients' personal symbolic meanings of their diseases as emergent from their experiences of EFT therapy. This chapter constitutes a journal article manuscript whose reference is provided below. This chapter uses a third person voice as per the requirements of the journal. Three themes are presented in this chapter, namely: 'disease as an embodiment of unresolved emotional issues', 'disease as body's call for time-out and attention', and 'disease as a boundary from other people'.

## Chapter Contents: Journal article

This chapter comprises the following journal article manuscript:

Kalla, M., Simmons, M., Robinson, A., & Stapleton, P. (2017). Making sense of chronic disease using Emotional Freedom Techniques (EFT): An existential view of illness. *Disability and Rehabilitation*, under review.

A copy of the aforementioned journal article manuscript is included in the thesis as follows. I have not renumbered the pages of the manuscript with the view to include the manuscript in its original form.



# **Making sense of chronic disease using Emotional Freedom Techniques (EFT): An existential view of illness**

Running Head: Making sense of disease

Article category: Research Paper

Mahima Kalla<sup>1</sup>, Margaret Simmons<sup>1</sup>, Anske Robinson<sup>1</sup>, Peta Stapleton<sup>2</sup>

<sup>1</sup> School of Rural Health, Monash University, Melbourne, Australia

<sup>2</sup> Faculty of Society & Design, Bond University, Gold Coast, Australia

Corresponding Author: Mahima Kalla

Mail: School of Rural Health (MUDRIH), [REDACTED] (Australia)

Telephone: [REDACTED]

Fax: +[REDACTED]

Email: [REDACTED]

Declaration of interest: The authors report no conflicts of interest.



## **Implications for Rehabilitation**

- Rehabilitation professionals should incorporate suitable psychological interventions (e.g. EFT) to assist patients make sense of their illness experiences in the context of the patients' life-worlds.
- Rehabilitation professionals should help patients address unresolved emotional issues associated with past experiences.
- Rehabilitation professionals are recommended to help patients make sense of any 'secondary gains' associated with their illnesses to assist patients' overall recovery.

## **Making sense of chronic disease using Emotional Freedom Techniques (EFT): An existential view of illness**

### **Abstract**

Purpose: ‘Symbolic Disease’ represents a phenomenon wherein the pathology of a disease appears to express the same story and meaning as the patient’s personal subjective story. This article explores chronic disease patients’ personal symbolic meanings of their diseases, as emergent from their experience of Emotional Freedom Techniques (EFT) therapy. The present study is part of a larger study that explored chronic disease patients’ and EFT practitioners’ experiences of using EFT to support chronic disease healthcare.

Methods: Eight chronic disease patients who had used EFT to make sense of their illness experiences were interviewed for this study. Semi-structured interviews were conducted via face-to-face, or via telephone/online videoconferencing platform, Zoom. Interviews were transcribed verbatim and data was analysed using Interpretative Phenomenological Analysis methodology.

Results and conclusion: Three themes emerged, namely ‘disease as an embodiment of unresolved emotional issues’, ‘disease as body’s call for time-out and attention’, and ‘disease as a boundary from other people’. The findings suggest that a suitable therapeutic approach that helps chronic disease patients make sense of their life stories and lived experiences and symbolic meanings of diseases may offer therapeutic value to patients.

*Key words: Emotional Freedom Techniques (EFT); chronic disease; Interpretative Phenomenological Analysis (IPA); symbolic disease; illness construction, lived body*

## Introduction

From a biomedicine perspective, the human body is a functioning objective biological machine, and disease is a digression from that “biological norm” (1, p. 9). A disease is often considered to have an “objectivity” which doctors can usually measure (1, p. 9). Biomedicine is primarily concerned with the cause and cure of diseases. Wilberg (2) presented an alternative, existential view of disease which aims to search for the *meaning*, rather than the *cause* of a disease and its symptoms.

Wilberg (2) argued that this existential perspective of disease is phenomenological in that it is concerned with patients’ lived experiences of disease, and hermeneutic in that it views the human body as a “living biological language” (2, p. 308). The ‘lived body’ is the body that is ‘felt’ by a person from within (2). Unlike the ‘clinical body’ which can be objectively examined by medical professionals, the ‘lived’ body is a subjective embodiment and expression of a person’s internal state of being or consciousness. Symptoms are seen as “messengers” of the patient’s story, or subjective lived experience (2, p. 208). Wilberg (2) questioned whether somatic states such as diseases and physical symptoms impact a person’s psychological state, or if those somatic states are instead, expressions or embodiments of a person’s psychological state or consciousness. Wilberg (2) contested the reductionist view of disease to biological causes, or misfortune, and speculates if the occurrence of a specific disease at a specific *time* in a person’s life represents or holds a particular meaning in the broader existential framework of the person’s lived world.

In addition, Broom (3) discussed the phenomenon of ‘somatic metaphor’. A ‘somatic metaphor’ becomes evident when:

a physical disease - in its pathology, the organ(s) involved, and/or its body location - appears to be ‘saying’ the same thing, expressing the same meaning, as the patient's subjective ‘story’, conveyed in verbal language or in the pattern of important and meaningful events in the life of the patient (3, p. 16).

Broom (3) advocated for the need to move beyond biomedical and biopsychosocial models, to a unified 'personhood' approach based on the premise that a patient's subjective reality has a crucial role in the development and maintenance of disease, and in recovery from it. Physical diseases, which seem to be somatic metaphors of patients' meanings and subjective stories, are referred to as 'symbolic diseases' (4). Broom et al. (4) recommend a clinical approach, which involves the clinician working with the client to explore the client's personal meanings, life experiences, and stories in an attempt to understand the symbology of disease.

Psychotherapy interventions may assist patients make sense of their lived experiences, and the symbolic meanings of their diseases. A contemporary psychotherapeutic tool, called Emotional Freedom Techniques (EFT), also known as 'Tapping', may be used to help understand people's subjective meanings and disease symbology, and co-construct new meanings to facilitate healing.

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

Emotional Freedom Techniques (EFT) is a therapeutic modality which combines Chinese acupuncture with Western psychotherapeutic principles. The application process of EFT has been documented by Craig and Fowlie (5) and by Church (6). In a typical 'round' of EFT, a subject first consciously invokes, or is psychologically exposed to a specific emotional trigger, such as a distressing memory, negative emotion (e.g. anger, fear), object of phobia etc. The subject then 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 gently taps on certain acupoints on the face and upper body with his/her fingertips, while focusing on the distressing emotional trigger at hand, 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 (5; 6).

Several studies and review articles have been published in peer reviewed psychology and medical journals examining the efficacy of EFT therapy for various mental and physical health conditions. Meta-analyses of clinical trials indicate a large treatment effect of EFT treatments for anxiety, depression, and PTSD symptoms (7; 8; 9). Studies investigating the effects of EFT on physical chronic health problems such as tension headaches (10), obesity (11), traumatic brain injury (12), chronic pain (13), and psoriasis (14) have also been published.

There are various proposed hypotheses in relation to the mechanism of action in EFT. For example, EFT may have potential effects on the body’s physiological systems that regulate stress, emotional intensity, and associated neural transmission frequencies (15). Additionally, EFT treatment appears to decrease activity in the amygdala, leading to calming of the ‘fight, flight, freeze’ threat response to emotional triggers (16). Furthermore, the aspect of self-acceptance statements in the EFT process may also be instrumental in reducing suffering, similar to other interventions such as Cognitive Behavioural Therapy and Mindfulness which rely on the premise that acceptance of, rather than resistance to, a particular condition reduces suffering (17).

### ***Study Aim***

The present study forms part of a larger PhD research project that explored EFT practitioners’ and chronic disease patients’ lived experiences of using EFT to support chronic disease healthcare. Part of the broader study’s findings relating to EFT practitioners’ experiences of using EFT to support chronic disease healthcare have been published in (18). Another emergent

theme from the larger study related to the application of EFT to help patients make sense of their life stories and lived experiences, and construction of disease symbology. The present study explores chronic disease patients' personal symbolic meanings of their diseases, as emergent from their experience of using EFT therapy. This article presents the meanings ascribed by the study's participants to their illnesses through their EFT therapy experience. The focus of the present article is therefore on the emergent meanings themselves, rather than the process of EFT therapy. Further information on the process of EFT therapy may be found in (18).

## **Methods**

### ***Theoretical approach***

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 and meaning-making (19). A constructivist epistemological position (different from a *constructionist*) was assumed for this study. A constructivist view posits that people receive knowledge through their senses, and/or communication, and interpret and actively construct their reality based on their experiences, and interactions with their environment (20). According to constructivism, "knowledge does not reflect an objective, ontological reality but exclusively an ordering and organization of a world constituted by our experience" (21, p. 24).

Von Glasersfeld (22) suggests that cognition is adaptive, i.e. it helps people organise their experiential world reality, rather than discover an absolute truth, or objective reality. Constructivism further suggests that the meanings created by people are continually tested against previous knowledge and either reinforced or modified in line with new experiences (23). Von Glasersfeld (20, p. 7) proposes the concept of 'viability', wherein the focus is not on

an absolute truth that accurately matches an objective reality, rather, “concepts, models, theories, and so on, are viable if they prove adequate in the contexts in which they were created”. Psychotherapeutic approaches, (in this case, EFT), often aim to help patients and their therapists collaborate to make sense of patients’ lived experiences through an interpretative process, and co-construct positive or more productive meanings about seemingly difficult experiences or circumstances.

### ***Interpretative Phenomenological Analysis***

One of the many qualitative research paradigms is the approach of ‘phenomenology’. Phenomenology refers to the study of structures of experience, or consciousness (24, 25). The approach of phenomenology has evolved through the work of numerous philosophers and thinkers, among whom is the philosopher, Martin Heidegger (24). Heidegger proposed the concept of interpretative phenomenology which posits that humans are embedded in the context of their lifeworld (e.g. comprising objects, language, and relationships); therefore, humans’ experiences are subjective, and dependent on their own perspectives (24, 25). Over the last few decades, phenomenological theorists 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.

Interpretative Phenomenological Analysis (IPA) is a contemporary research methodology which was developed to study people’s unique subjective experiences using an interpretative approach (25). IPA aims to explore participants’ lived experience, meanings, and perceptions. IPA has its origins in theories which posit that humans do not passively consume information about an objective reality, rather, they actively interpret and endeavour to understand their experiential world by formulating their own meanings and organising their

biographical stories in a form that makes sense to them (26). IPA was thought to be commensurate with firstly a constructivist epistemological position, and secondly, the study's aim to explore chronic disease patients' lived experiences, and meaning-making.

IPA is underpinned by three theoretical pillars: phenomenology, hermeneutics and idiography (27). IPA is concerned with the study of lived experience (phenomenology). IPA also involves a double-hermeneutic or interpretative component, whereby the participant first interprets his/her own meaning-making and experience in the telling, and the researcher then interprets the participant's account of his/her experience and meaning-making. Finally, IPA is also idiographic, i.e. it is concerned with the detailed explication of 'unique' or individual cases, which means that only a small sample size is necessary, even appropriate (28).

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

In alignment with the idiographic nature of IPA, purposive sampling of a small well-defined homogenous group of participants for whom the research question is relevant, is required (29). 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 (26). This article was a part of an overarching study, which was approved by the [Ethics Committee name withheld for blind peer review]. Participants were recruited through EFT interest groups, namely, 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 that participants had to be physical chronic disease patients aged over 18 years who had used EFT as part of their healthcare regimes. People with cognitive impairments, intellectual disabilities, or mental



illnesses, pregnant women, and patients under palliative care were excluded from this study due to ethics requirements.

Given that EFT is a relatively contemporary tool, placing geographic and/or 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. Despite the socio-demographic diversity, the sample for the present study is homogenous in terms of participants’ suffering from physical chronic diseases who had used a specific therapeutic tool (EFT) to support their healthcare. Respondents to advertisements were screened by asking questions via email or telephone, about their health conditions, and their use of EFT, as part of purposive sampling.

Given IPA’s idiographic focus, sample sizes are often small (28). Sample sizes may be as small as five or six participants (27). Eight chronic disease patients (all female), located across Australia (three), UK (three), Canada (one), and USA (one) were interviewed for this study. There was no intention to exclude other genders from the study. However, only women responded to the advertisement calling for research participants. Since the predominance of females in the sample was a matter of chance rather than an intended outcome, a feminist methodological basis for the study was not explored or considered - although it might be useful for explorations in further studies. Further discussion on the implications of the all-female study sample is provided in the limitations section at the end of the article.

The chronic illnesses within the emergent study sample included Mast Cell Activation Disorder, Chronic Fatigue Syndrome (CFS), Fibromyalgia, Chronic Migraines, Crohn’s Disease, and Arthritis. Given that EFT is a contemporary therapeutic intervention and its emerging evidence base is relatively new, the researchers decided to not restrict the kind of chronic illnesses under consideration in order to enable broad data generation within the context of generic patient healthcare, rather than disease-specific care. As such, inclusion

criteria were not placed on the type of chronic diseases under consideration for the larger research study. A further discussion of the aforementioned study design aspect has been provided in the limitations section later in this article. 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 (30), were used in the present research. Semi-structured interviews serve as intentional conversations that allow researchers to elicit targeted detailed information from participants (27; 31). Because most participants were based interstate or overseas, interviews were also considered to be the most viable form of data collection. The participants were interviewed via telephone or Zoom (a video-conferencing platform) and the interviews lasted between 60 – 120 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 mostly left open-ended so that participants could freely and descriptively share their experiences (31). Participants were asked questions about their experiences of illness (e.g. when it started, symptoms, impacts on quality of life), experiences of using EFT, personal meanings of disease, personal notions of recovery, and general perceptions about EFT as a technique. For example:

- Can you please tell me a bit about your problem or illness?
- How were you introduced to EFT and why did you decide to try it?

- Can you elaborate on your experience of using EFT to support your chronic disease healthcare?
- What sort of emotional issues did you address in your EFT sessions?

Further questions emerged as the interviews progressed as per the semi-structured interview approach (30). 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 (27).

### ***Data analysis***

The IPA data analysis process as described by Smith et al. (27) was employed for this study.

Overall, the data analysis process encompassed:

1. Revisiting the data: reviewing interview notes, listening to an interview recording, and reading of an interview transcript.
2. Initial note-taking to capture points of interest: a non-exhaustive and iterative exercise which involved making detailed comments and notes on the data and engaging with the data both broadly and in-depth. Comments were made on the similarities and differences, extensions and inconsistencies in the participants' accounts.
3. Synthesising preliminary themes by reviewing exploratory notes: reviewing exploratory notes developed in the above step, then rearranging and restructuring the data into smaller manageable pieces and subsequently, 'themes'.
4. Grouping and organising emerging themes to structure data: organising themes based on their similarities, differences and contextual settings. This step was defined by the scope of the research question. Themes were clustered together under categories, also

known as ‘super-ordinate themes’. Super-ordinate and their constituent sub-themes represent a hierarchical or relational structure between the emergent themes.

5. Reviewing the next case: upon completion of the above steps for a given piece of data, moving to the subsequent piece of data (e.g. another participant’s interview transcript) and repeating steps 1 – 4. As per 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: identifying connections between the various cases and their themes. Consequently, restructuring and renaming the themes to ensure 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 discussed with the second and third authors (PhD supervisors), both of whom have extensive expertise in qualitative research methods. Smith et al. (27) endorse collaboration between students and supervisors throughout the research process, including data analysis.

Additionally, a data analysis ‘workshop’ was undertaken with the study supervisors as a ‘triangulation’ exercise. This workshop assisted in further enhancing the interpretative rigour of the data analysis process, and synthesising the emergent themes. Kitto, Chesters and Grbich (32) argue that discussion among researchers can help enhance the interpretative rigour in the study, and help broaden and refine the data analysis findings.

Brocki and Wearden (26) highlight the importance of employing reflexive procedures in IPA. To enhance rigour in the execution of research, consideration of personal known and emergent conceptions, and emotional responses to the data is important (26). Therefore,

reflexive note-taking was undertaken 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, data collection, to data analysis, and writing up of findings.

## **Findings**

During the interviews, participants talked about their personal symbolic meanings of their diseases, as emergent from their experience of EFT therapy. Three major themes emerged regarding participants' symbology of their diseases, namely, 'disease as an embodiment of unresolved emotional issues', 'disease as the body's call for time-out and attention', and 'disease as a boundary from other people'. This section unpacks the aforementioned themes.

### ***Disease as an embodiment of unresolved emotional issues***

The first theme emerging from the data was when participants talked about disease as an embodiment of unresolved emotional issues. Participants noted that they perceived physical disease to have a strong correlation with emotional and mental health. For example:

Physical stuff happens because of the emotion, not just because you're not a good person or ... you have a germ that's gotten bad (Hannah, Crohn's Disease patient)

In the above quote, Hannah appears to perceive a strong, almost causal relation between emotional and physical health. She indicates that 'disease' does not represent a 'punishment' for not being a good person, or a case of 'biological misfortune'; rather it is a function of emotional wellbeing, or lack thereof.

Chronic fatigue syndrome patient (CFS), Fleur, elaborated on her understanding of the connection between her emotional issues and physical disease:

I think what became apparent when I found EFT, what I hadn't thought about, was that I was doing all this stuff for my health ... like I was eating really well, and doing all the things I am meant to be doing, and I had just started to meditate as well, which would help me sleep. And, I felt like you know I was also pushing myself, and I was doing all this stuff, but I was not really getting, really far. And when I found EFT, I realised that it could be underlying things that were keeping me unwell, and I hadn't really considered that. I hadn't really considered that this illness could have come about because of my history, basically. So, it made me... start to really look at you know, what I had been through in my life, and how I could resolve those traumatic events and ... and those habits and programs I was running, and my beliefs and things like that. And it made me realise ... that it was *all that* really that had made me unwell, and it was all that, that was going to help me get well. (Fleur, CFS patient)

Fleur's quote points to her search for the 'missing piece of the puzzle' in her healthcare regime. It appears that the healing of emotional issues such as past traumas and negative beliefs through her use of EFT was this missing piece for Fleur. She alludes to a sense of 'latency' of the unresolved emotional issues, and EFT becoming a trigger for understanding those unresolved issues from her past and subsequent healing. Similar to Hannah's previous quote, Fleur also perceives a strong correlation between her life story and unresolved emotional issues from her past, and her physical disease.

Another CFS patient, Kayley, recounted her understanding of the role of emotions in hampering her physical health:

My first therapist told me about psychosomatic disorders ... I knew, deep inside that, I was ill because of emotional stuff, because I had never been happy and okay in my life. And I knew that. I knew that was a place to start. But, I still thought my chronic fatigue would have to be cured in a physical way. I still felt like I was not in control of my body. My body was controlling me. And I might never get better, that sort of feeling I had, and so, he taught me to believe that I *was* in control. It didn't feel like I was in

control. My subconscious was controlling exactly what was happening in my body. And I could ... look at as much of the subconscious stuff and manage to bring up and heal it, that my body would know what to do. That the body is meant to be healthy ... There is something in the way of it being healthy, but really the body will go back to full health if it is given the chance. (Kayley, CFS patient)

Unlike Fleur who apparently did not consider the connection between emotional issues and physical health, Kayley points to a sense of ‘inner knowing’ about the impact of her emotional state on her physical health. Concomitantly, Kayley also appears to undergo a change in her perception of the locus of control of her physical health; from initially feeling like her body was controlling her, to then thinking that her subconscious mind was controlling her bodily health, or lack thereof. Like Fleur, Kayley points to the ‘latency’, or ‘subconscious’ nature of unresolved issues. Also noteworthy from Kayley’s quote is an apparent personification or anthropomorphisation of the physical body, as if the body has a mind or conscious intelligence of its own and ability to undertake conscious action, illustrated by “my body would know what to do”. Additionally, Kayley discusses an interesting view of health and disease. She indicates that full health is the body’s ‘default’ state, but emotional issues can contribute to the body losing its healthful state.

Participants talked about the embodiment of unresolved emotions as physical problems in the body. For example:

My husband passed away almost 20 years ago. My children were really young at that time. So, there was really no time to stop and feel grief. And realising that it was all those emotions that had been locked up. And, what I uncovered through EFT, was that I was afraid what I am going to do next ... The lower back pain was crucial, and that was gone in like one major session that we did. And, the pain was gone. It was like literally gone [laughs]. It was emotions ... and attachment ... that I was ‘holding in the back’. And, it seemed like there was a lot of responsibility that I take on, not just of my children, but ... of my parents ... You know ... overnight when it cleared, I was like, “oh my God!”, you know, “it's just gone!” And, here I was, clinging on to stuff that I didn't even know. (Rhea, Arthritis patient)

Rhea's quote points to her perception of pain as the somatisation or embodiment of unresolved emotional issues, illustrated through the expression "holding" emotions and attachment in her back. Rhea also points to a similar 'latency' of unresolved emotional issues, as discussed previously. Additionally, Rhea's use of the expression, "emotions that had been locked up" is to be noted. She appears to represent unresolved emotions as being able to, be metaphorically, 'trapped' in the body, which may then require a suitable intervention (in this case EFT) to release. In Rhea's quote, there is also a notion of a 'magic cure' of her back pain, once the emotional issues were addressed.

CFS patient Fleur, further elaborated on the symbology of physical disease, and the juxtaposition of emotional meanings and physical health issues:

It became apparent that a lot of the stuff going on in my body was there to stop me from thinking about the abuse and how I disliked myself. This intense headache that I had, and the jaw pain, really severe jaw and neck pain... the brain fog... When I started delving into it... I realised that it is actually there to protect me. Because before that, I had just been constantly over thinking, just in a state of despair, pretty much all the time, unless I was drinking or something. So, yeah, I believe ... what's going on in our body is... there as an invitation for us to heal. And, I believe that, you know, our body does try to protect us. And we see it as ailment. But, actually it's our body trying to lessen our blow almost, to what we are doing up here [pointing to forehead/mind]. (Fleur, CFS patient)

Fleur presents an interesting symbology of disease as being a protection or coping mechanism from emotional unrest. Fleur's quote also points to an anthropomorphisation of the physical body and a view of the body as having its own intelligence and coping mechanisms, and represents an embodied illness. Furthermore, Fleur discusses a positive outlook on disease as a trigger for changing long-standing emotional patterns.

Arthritis patient Rhea, also said in relation to her back pain:

The pain was just something that the body was trying to tell me about [laughs]. (Rhea, Arthritis patient)



Rhea's quote further illustrates an anthropomorphisation of the physical body, representing the pain as part of the body's language; as being a 'messenger' of the body.

Another participant, Alicia described her experience of using EFT to address emotional issues:

The things that I was left with to work on, in EFT... could not have more closely modelled the themes if you like, in my life, at the time. [Laughs] ... It was like [exclaims] "Seriously?!" Yeah, so the themes... you know, the experiences I have, and the beliefs I formed about myself. (Alicia, Mast Cell Activation Disorder and CFS patient)

Alicia points to her condition as a metaphorical representation of her life experiences, and beliefs. In fact, her quote suggests that the reflection of her life history and lived world, in her health condition was almost 'uncanny'.

### ***Disease as a call for 'time-out' and attention***

Participants discussed long-standing behavioural patterns of 'pushing' themselves to the point of exhaustion and a physical state vulnerable to illness. Participants suggested that unresolved emotional issues and limiting beliefs may contribute to these unhelpful behavioural patterns. For example:

The main thing for me, with those conditions was fear.... The belief that I have to be strong. I kind of like have to brace for things. I have to do them alone. I shouldn't complain. Those are the beliefs that I really actually had to work on ... Both my parents were war veterans. And, both of them had actually injury to their head. So, you know when you get that combination, it can be very explosive ... You know there was alcoholism in the family, lots of violence. So, I learnt ... that I need to be independent. And, I have to look after myself. Don't complain you know, when you are sick. You have to find your own way, don't tell people... And, don't give yourself that much attention. Just keep going. Just keep going, keep working ... So, then ... I keep going when I am not well, and I tense. You know, I feel tense inside, and I start tensing the body. And, then, be [a] good girl ... Be the good girl. Be the good girl, the good girl ... And, rather than relaxing and taking it easy, telling people I am sick, and I can't come to work, when I started

feeling the symptoms that day. And, I was like, “no you are going to work” ... You know it was the physical exhaustion ... Like, it was the body asking, like the body sending me signals. It calls you to attention. It just stops you [chuckles] ... [the body says] “just stop and give me and attention”. (Candace, Fibromyalgia and migraine patient)

In the above quote, Candace provides several examples of emotional issues and beliefs that she perceives to have contributed to her behavioural pattern of over-doing and pushing her body beyond its limit. Candace also suggests that unproductive behavioural patterns may have their origins in childhood and difficult experiences in early life. She presents a poignant cultural narrative of “being the good girl”, i.e. being responsible and meeting her commitments and not complaining, even if that meant not looking after herself when she was sick. Candace’s quote, also presents a personification of the physical body and illness as the body’s messenger, an expression of the body’s need to be cared for, and attended to.

Another participant, Alicia, described her journey from constantly over-doing to the point of exhaustion to now pacing herself:

The other expectation which was really big and has been really big in terms of my healing journey was the need to push on. This whole you know... other people are depending on me. I have just got to... push through it. That whole dynamic, I have realised isn't working for me.

The biggest challenge has been to not over stimulate my body. So, pushing through the tiredness, thinking if I get it done, I can you know, relax... And very much within, you know the way I was brought up was just "suck it up". And so, a very large part of my current journey, and to a certain extent, my work in EFT has been, not doing that, and working out, what I refer to as "hell yeah, I want to do that". Like, "really, why am I doing this?" ... So picking my battles, and ... simplifying my life, and ... doing what really matters to me. (Alicia, Mast Cell Activation Disorder and CFS patient)

Alicia’s quote also suggests a tendency to push herself to the point of tiredness and fatigue, and helping others at the expense of her own well-being. Alicia also presents a significant cultural

narrative of enduring distress without complaining, as evidenced by her use of the vernacular expression, “suck it up”. Alicia’s quote points to her use of EFT to bring about greater self-awareness and assist her decision-making regarding her daily life activities.

Another CFS patient, Cassandra, recounted a similar behavioural and emotional pattern:

I learned also as a child, I had to take care of everything myself if I wanted it done, or done the way I thought it should be done ... So, there’s something about, I would have to do it, all anyway ... if things were gonna get done, which is not very useful and adds to your fatigue, so you know I really had to deal with some of that. (Cassandra, CFS patient)

Cassandra’s quote points to a sense of lack of social support in her life. It also suggests a lack of trust in the quality of work done by other people, and consequent inability to delegate, and tendency to over-work.

CFS patient, Daisy, also described her long-standing behavioural patterns of over-doing beyond her physical capacity:

I was a very driven person, so I fitted that classic thing of, just not stopping, always wanting to do. I used to compete, show jumping and different kind of things when I was a teenager. That was really [laughs] tiring and exhausting. I was quite full on, [there were] at least two days every week where I was competing... It was really physical. I was also a music journalist in my teens and my twenties... Again that was something that was kind of like a lifestyle more than just a job. Work was really full on and then you would always be leaving work to go to an album launch or a gig that went on really late at night. So, again that was more, [laughs] more exhausting myself ... So I suppose it’s all a perfect recipe for gaining chronic fatigue syndrome ... I didn’t really know [laughs] that I was meant to pace myself or I wasn’t meant to push myself, that that was a really bad idea ... I don’t think there really was an understanding that there is now that you’re meant to pace [laughs] and look after yourself. [Laughs] ... I was really driven all the time. ... I used to always push myself to do things that were exhausting, and make me feel ill ... kind of exhausting myself in the pursuit of goals. (Daisy, CFS patient)

Daisy introduces another dimension to this theme, i.e. over-achievement. Additionally, Daisy's apparent self-deprecating laughter at her lack of understanding of the importance of self-care as a young person, which is so obvious to her now, illustrates a strong change in her behavioural patterns.

In addition to representing disease as a call for 'time-out', participants also discussed their view of disease as a call for 'attention'. For example:

I cleared [the belief] that I don't deserve love ... As a child, as a young child, I would get sick to get attention. (Hannah, Crohn's disease patient)

Hannah's quote is interesting in that it points to an almost 'conscious' act of getting sick, as a child to fulfil her emotional need for attention. Her quote points to a sense of low self-worth, such that it was only okay for her to receive attention when she was sick.

Arthritis patient Rhea, recounted a similar experience:

... Another belief was having discovered recently, is... as a child, being sick got attention, and that has been a very significant one that I actually uncovered recently within the last few days, and that was a big one, because it is the under-current of your body going into this mode, that you don't realise what is going on, but it is very deep level. So, EFT is magic for uncovering beliefs, and not just uncovering, but also to realise that yes it was true then, and be curious now. (Rhea, Arthritis patient)

In the above quote, Rhea suggests that the belief that "getting sick got attention" formed during her childhood was potentially having impacts on her physical health, even as an adult. She also highlights the importance of recognising that such a belief that might warrant consideration for healing, despite appearing unreasonable to an adult.

*Disease as a 'boundary' from other people*

Participants presented their view of illness as a 'boundary' or barrier from other people. Participants described their tendencies to over-empathise with other people, or 'over-help' others to a point that their own needs were compromised. For example:

I also became sort of therapist to most of my friends and from a very very young age. And a lot of my friends did actually have major trauma and major abuse. So, I sort of carried that for them and so that sort of thing became my own stuff even though it was not really mine.... My mum was a very big helper. She was always helping other people, and giving up her own things for other people. And she expected me to do the same. And any time I couldn't or I didn't want to, then she basically told me I was being selfish. There was no room for me to have needs basically. I was meant to be giving, giving to everybody ... The thing of being not well was quite difficult. [But] that was the only way for me to get attention I needed. I used to get... not attention, but like space to get my needs met. Because it was always other people who were the most needy... the people in the world we looked after, people who were worse off than us... So I guess I had to make myself worse off than everybody else in order to be looked after and given the space that I needed to not have to help people anymore because I couldn't.... I wasn't allowed to have needs, to have boundaries. So, that was my boundary. I had a reason why I couldn't give to people, and I didn't want to feel guilty about it, whenever I did. At certain points, I felt guilty that I couldn't do more because I was ill. But that was the only way my body knew to deal with, with not being able to cope with my life any more. (Kayley, CFS patient)

Kayley's quote points to a sense of heightened empathy for other people's suffering to the point that the distinction between her own and other people's distress was lost. There is also an expectation of following the familial practice of giving and helping those in distress at the expense of self. Kayley's quote suggests the disempowering effect of serving others on her own well-being. Her quote also suggests a lack of personal agency in her life about making decisions on who she wanted to help, and constantly having to live up to the expectations of other people, e.g. her mother. There is also a notion of needing 'permission' from others to look after herself. Additionally, similar to instances discussed previously, Kayley's quote

points to a sense of a personification of the physical body; as if the body has its own intelligence, and ability to undertake conscious subjective action. She alludes to her disease, in her body's language, as a protection, or coping mechanism for the distress that she was feeling; as if the disease was the body's way of legitimising her need for personal boundaries, and self-care.

Fibromyalgia patient Candace, also described her lack of self-care, and tendency to put other people before herself:

[From a] physical point of view, care for yourself. Because, you know, I was running around, taking care of everyone else ... Mothers sometimes do that. And ... if I think back long time, [I had the belief that] family is first. You know, and I am like a second ... that's my biggest lesson, actually ... That I am equal with my family ... We are all equal ... That's the biggest, the hardest lesson. (Candace, Fibromyalgia and migraine patient)

Candace's quote suggests that the propensity to always put other people first may sometimes stem from cultural and social expectations of certain societal roles. Candace's account portrays the cultural narrative of the hard-working mother and selfless feminine figure who serves her family righteously without regard for herself. She suggests that such a behavioural pattern fuelled by the cultural expectations of mothers caused her to 'burn out'.

A previous quote by CFS patient Kayley, described her heightened sense of empathy. Similar to Kayley, another participant Hannah, described her tendency to over-empathise with other people's suffering, and its impact on her physical well-being:

I don't know if you know, but well, for me anyway, I get pain because I'm an empath; I feel other people's pain ... 85% of what I feel physically in my body is not mine ... I have a "secondary gain", I think it's called. If the Crohn's goes, I will have no excuse to hide ... Because as an empath, [I am] constantly inputting, and constantly picking up without a choice, because you can't stop it coming at you. I am always looking for a safe place to hide. Always. I sit at the back of rooms; I don't go to movies very

much unless I really like the movie. I stay away from crowds ... I would say no to social events. It would have given me the excuse to "oh, I'm just too tired", "I'm just too sick", "I can't go", "I can't do".  
(Hannah, Crohn's Disease patient)

Hannah's quote points to the somatisation of her perception of other people's pain in her own body. She also alludes to the involuntary nature of her hyper-sensitive empathetic tendencies and a lack of control over her body. She also presents an interesting concept of 'secondary gains', or benefits of having an illness. She presents her perception of her disease as offering a refuge from other people, and a reasonable justification for not engaging in social interactions and activities.

Other participants also described similar secondary benefits offered by their diseases, whereby their diseases served as boundaries from people. For example:

One of the other things that was a big shift for me was I started looking into, from actually a workshop that I attended from my EFT trainer, I started looking into secondary gains ... When he did the workshop, I thought, "well I haven't got any secondary gains. I don't know what you are on about?" [Laughs] And then afterwards I thought, "I really have, actually". You don't want to believe that you have got some thoughts there that are keeping you ill. And mine was, when I started to get unwell, I realised that I didn't have to attend things I didn't want to. I didn't have to do things I didn't want to. I didn't have to see people I didn't want to. And it came quite that side of it, that illness [was] quite convenient. Because I had never been good at saying no. I never had barriers. I just used to run around trying to help everyone all the time, despite what was going on with me. So, that side of the illness made me a little bit selfish, but in a way that I should have been being anyway for myself. So, when I came across this idea of secondary gains, I realised that, that was my secondary gain. That I didn't want to, when I was well again I didn't want to start socialising with people, I didn't want to socialise with. I didn't want to go to family events I didn't like or go to places with people I didn't want to or work at a job that I didn't want to work in. So, when I started working on those through Tapping, again there were big shifts there as well. I felt that energetically, physically, mentally everything. (Fleur, CFS patient)

Fleur's quote presents the notion of her illness as offering a 'refuge' in the face of a long-standing behavioural pattern of lack of self-care and helping other people at the expense of self. Fleur suggests development of a greater sense of self-awareness and improved self-agency acquired through the process of EFT. Fleur alludes to her growth from metaphorically, relying on a disease to provide her the 'space' or 'refuge' that she needed, to becoming an empowered decision-maker about the choices she made in her life, e.g. who she socialised with, or the kind of employment she engaged in.

Similar to Fleur, Daisy, also described her perception of her illness as a boundary, and subsequently elaborated on her use of EFT for reinforcing boundaries, and dealing with these issues in more productive ways:

If I'm, shut in and I can't go out and I can't do as much stuff, then in a way there's a certain amount of safety in that. And also, it kind of gives, I know when I was younger, it kind of gave me permission not to go out and not to do things and it was something that people would have to listen to. "Well I can't go out because I'm ill. So, I don't want to go. I can't because [laughs] I'm ill". And I suppose the pressure when you're younger as well, to constantly be out doing something so... it was a kind of excuse not to... Just to be able to be inside and not interacting... having some time off I suppose. That was one of my big fears ... It was a big feeling that if I get well I'm gonna have to be... It kind of felt like I'd go from being inside and doing nothing to, having a full-time job again, and I suppose it's making realizations that "oh, you can choose to just work part-time" ... So, I suppose as well, it's kind of not, not taking your power if you're ill. Kind of going "actually, this is who I am, and this is how I need to live my life for it to work for me and to be well" ... Whereas you try and fit in with how things are and then get really ill ... You can avoid [that] in going, "No, actually I need to do it this way for me". (Daisy, CFS patient)

Daisy's quote also alludes to her illness serving as a legitimate reason for making certain decisions, which may not otherwise be well-liked by people, but were acceptable because of her illness. Daisy's laughter also alludes to her sense of a 'black humour' to her illness; despite being an uncomfortable experience, her illness acted as a convenient excuse for having



boundaries. Daisy subsequently highlights her journey to gaining an improved sense of confidence and empowerment, and feeling comfortable in her decisions to live her life as she chooses to support her personal needs and values rather than in accordance with societal norms.

## **Discussion**

The current article explored chronic disease patients' meaning-making of their diseases in their broader existential frameworks. Common themes that emerged explored patients' accounts of their diseases as 'somatic metaphors' of their life stories, emotional and behavioural patterns, and subjective life experiences. In phenomenological literature, as described by theorists such as Edmund Husserl, Merleau-Ponty, and Heidegger, there is a conceptualisation of the 'lived body' (33). The lived body is that which is lived by the person. The body is not an object situated in a world, instead, it is the person's view *of* the world (2; 33).

Kleinman (34) proposes that a disease can be more holistically understood as a manifestation of social or psychological trauma that is expressed via cultural narratives, and/or metaphors. As such, a clinician must not only appreciate the patient's physical body and symptoms as objects to be treated, but also as a subjective embodiment, or harbinger of the patient's biography, life experiences, and social interactions (34). Kleinman (34) also argues for the importance of giving patients the opportunity to recount and 're-present' their stories in their own words.

This article presented three themes emergent from chronic disease patient accounts, namely, 'disease as an embodiment of unresolved emotional issues', 'disease as a call for time-out and attention', and 'disease as a boundary from other people'. Participants often portrayed a 'personified' view of their physical bodies, as if the body has its own conscious intelligence, and ability to undertake conscious subjective action. They often referred to their diseases as being harbingers of their bodies' messages about the bodies' needs.

Participants described their perceptions of their diseases as embodiments of unresolved emotional issues. Wilberg (35) argues that every mental, emotional, or psychological state is also a bodily state. A mental state is not merely an entity contained within a person's mind or brain, but is also experienced or expressed in the body, and vice versa. Consequently, Wilberg (35) argues that aspects of illness should not be classified into 'mental' and 'physical' components. Instead, an illness is best viewed from a personhood approach, as postulated by the 'lived body' conceptualisation.

The second emergent theme explores patients' notion of disease as the body's call to attention and a trigger for 'time-out'. Participants discussed their behavioural patterns of pushing themselves too much, over-doing, over-achieving, having to be independent, and not expecting social support. Ware (36) presents research involving interviews with 50 chronic fatigue syndrome patients, to understand and identify themes in the participants' life histories and illness experiences. A common theme emergent from the study was around high personal standards for performance, difficulty saying 'no' to people, over-helping others, over-giving etc. Participants used terms such as 'workaholics', 'perfectionists', and people who 'would go all out', or 'push themselves to do more'. The participants claimed to give so much to others that they had very little resources left for themselves. Saltzman (37) has describes this as a "cult of busyness", an "exhausting lifestyle", that involves "over-doing, overworking, over trying to please everybody, and just over-everything". Ware (36, p. 72) also denotes this to be a "health-hazardous cultural morality".

Several cultural narratives presented in the current study include the 'good girl', and 'the selfless feminine figure, and hardworking mother'. Participants discussed their longstanding behavioural patterns of compromising their own needs for other people arising from patterns learnt in childhood, or exhibited as a result of unconsciously following societal expectations of certain roles. Chanfrault-Duchet (38) describes this as a conflict between the

‘self’ and the ‘society’. Simmons (39) presents the notion of the ‘curse of the good girl’, as a ‘psychological glass ceiling’, and a set of unsaid rules that ‘the good girl’ must follow, e.g. ‘not getting mad’, ‘not crossing the line’, ‘not having opinions’ etc. Simmons (39) argues that being unconditionally selfless, giving, or kind is an impossible pursuit, one that only renders females who aim to express this ‘goodness’, as perpetually self-critical due to not achieving these unachievable standards.

The final theme presented in this article was around ‘disease as a boundary from other people’. Participants discussed their perception of heightened empathy to other people’s suffering, and perceived somatisation of others’ suffering as pain or discomfort in their own bodies. There are two contesting viewpoints of empathy in phenomenological literature (40). The first view suggests that empathy allows for a ‘direct’ perceptual experience of another’s experience. The second view suggests that empathy is a person’s self-mediated, cognitive, indirect understanding of another’s experience. The participants’ accounts suggest that some participants appeared to feel that they were having direct experiences of other people’s pain, including some participants perceiving their empathetic experiences to be involuntary. Indeed, if they viewed their empathy as their own constructions of other people’s pain, they might not feel so disempowered and lacking control.

Participants also alluded to disease as a justification for soliciting attention. This may be considered as a ‘secondary gain’. Participants talked about their perceptions of ‘secondary gains’ or ‘benefits’ of having diseases. Their diseases provided them ‘legitimate’ reasons to justify their lack of social interactions, inability to engage in employment, inadequacy to help people at the expense of self. Disease was perceived by the participants, as offering a ‘refuge’ or ‘space’. ‘Secondary gains’ is a concept that first emerged in psychoanalytic literature (41). Fishbain, Rosomoff, Cutler and Rosomoff (41) suggest that secondary gains can have direct correlation with illness behaviour. Davidhizar (42) also indicates that secondary gains may

contribute to patients' wanting to continue to 'remain in the sick role'. While the concept of secondary gains is discussed almost as a 'conscious' act of using illness to personal advantage, the study's participants, however, alluded to 'secondary gains' as notions or meanings that they constructed while making sense of their diseases through their experience of EFT therapy.

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

The themes emergent from this study allude to the view of illnesses serving a 'purpose' in the patients' life-worlds. The anthropomorphisation of illness and the body by the patients through notions such as the body using illness as a means to get the patient's attention, imploring a period of rest, or a break from constantly helping others at the expense of personal well-being, points to the patients' recognition of their previous unproductive health behaviours. It appears from the patients' accounts that upon making sense of their illness experiences, they were able to gain new insights about their previous unhealthy thought and behaviour patterns and consequently inculcate more healthful patterns. It thus appears that illness constructions and meaning-making of illness experiences may offer therapeutic value to patients, not only in an existential sense, but also as a means of prompting recognition of current and past unhealthy thought and behaviour patterns, and development of new healthful behaviours.

### **Limitations of study**

The IPA methodology requires a participant sample to be homogenous. Most IPA studies incorporate homogeneity of participants' socio-demographic characteristics. In the current study, participants varied in age groups, and geographical locations, albeit all participants were based in developed countries. The homogeneity of the sample in the current study mainly arises from the participants' use of EFT to support their physical chronic disease healthcare. As participants were located in different countries, and countries vary in their public health care

systems and arrangements for their citizens, this could influence the experiences of the study's participants.

Since only women responded to the advertisement calling for research participants, other genders' experiences could not be explored. This might form the basis for another future research project. Out of the people expressing interest, those who met the inclusion criteria were shortlisted for the study. There was no intention to exclude other genders from the study, but it was a logistical or matter of chance in the study. Nevertheless, because the predominance of females in the sample was not an intended outcome, a feminist methodological basis for the study was not explored or considered - although it might be useful for explorations in further studies. It should also be noted that for the larger EFT study, however, one male EFT practitioner participant and one non-binary gender practitioner participant had been included. On another note, an all-female participant sample for this article, can also be seen to increase the homogeneity of the sample. Additionally, some researchers suggest that women are more likely to be impacted by long-term chronic illness which can affect their quality of life (e.g. 43). This study took various different 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**

This study explored chronic disease patients' personal symbolic meanings of their diseases as emergent from their experience of EFT therapy. Three major themes emerged in relation to patients' meanings of their diseases, namely 'disease as an embodiment of unresolved emotional issues', 'disease as body's call for time-out and attention', and 'disease as a

boundary from other people'. A disease may be phenomenologically viewed as serving a purpose in the broader existential framework of a person's lived world. A suitable therapeutic approach that helps chronic disease patients make sense of their life stories and lived experiences, and consequently, symbolic meanings of diseases, may offer therapeutic value to patients, from both an existential and a health behaviours perspective.

### **Acknowledgements**

We thank all the participants of this study.

### **Conflicts of Interest**

The authors declare no conflicts of interest.

### **References**

1. Boyd, K. (2000). Disease, illness, sickness, health, healing and wholeness: exploring some elusive concepts. *Medical Humanities*, 26(1), 9-17. doi:10.1136/mh.26.1.9
2. Wilberg, P. (2011). From Existential Psychotherapy to Existential Medicine. *Existential Analysis*, 22(2), 303-317.
3. Broom, B. (2002). Somatic metaphor: a clinical phenomenon pointing to a new model of disease, personhood, and physical reality. *Advances in Mind-Body Medicine*, 18(1):16-29.
4. Broom, B., Booth, R., & Schubert, C. (2012). Symbolic diseases and "mindbody" co-emergence. A challenge for psychoneuroimmunology. *Explore: The Journal of Science and Healing*, 8(1), 16-25. doi: 10.1016/j.explore.2011.10.005
5. Craig, G., & Fowlie, A. (1995). *Emotional freedom techniques: The manual*. Sea Ranch, CA: Gary Craig.
6. Church, D. (2013). *The EFT manual (3rd ed.)*. Santa Rosa, CA: Energy Psychology Press.
7. Clond, M. (2016). Emotional Freedom Techniques for anxiety: A systematic review

- with meta-analysis. *Journal of Nervous and Mental Disease*, 204, 388–395. doi: 10.1097/NMD.0000000000000483
8. Nelms, J. & Castel, D. (2016). A systematic review and meta-analysis of randomized and non-randomized trials of Emotional Freedom Techniques (EFT) for the treatment of depression. *Explore: The Journal of Science and Healing* (in press).
  9. Sebastian, B., & Nelms, J. (2016). Emotional Freedom Techniques (EFT) for posttraumatic stress disorder: A systematic review and meta-analysis. *Explore: The Journal of Science and Healing* (in press).
  10. Bougea, A. M., Spandideas, N., Alexopoulos, E. C., Thomaides, T., Chrousos, G. P., & Darviri, C. (2013). Effect of the Emotional Freedom Technique on perceived stress, quality of life, and cortisol salivary levels in tension-type headache sufferers: A randomized controlled trial. *Explore: The Journal of Science and Healing*, 9(2), 91-99. doi: 10.1016/j.explore.2012.12.005
  11. Stapleton, P., Sheldon, T., & Porter, B. (2012a). Clinical Benefits of Emotional Freedom Techniques on Food Cravings at 12-Months Follow-up: A Randomised Controlled Trial. *Energy Psychology: Theory, Research, and Treatment*, 4(1), 1-12. Retrieved from [http://www98.griffith.edu.au/dspace/bitstream/handle/10072/49453/81989\\_1.pdf?sequence=1](http://www98.griffith.edu.au/dspace/bitstream/handle/10072/49453/81989_1.pdf?sequence=1)
  12. Church, D., & Palmer-Hoffman, J. (2014). TBI symptoms improve after PTSD remediation with Emotional Freedom Techniques. *Traumatology*, 20(3), 172–181. Retrieved from <http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=2014-20843-001>
  13. Ortner, N., Palmer-Hoffman, J., & Clond, M. A. (2014). Effects of Emotional Freedom Techniques (EFT) on the reduction of chronic pain in adults: A pilot study. *Energy Psychology: Theory, Research, and Treatment*, 6(2), 14–21. doi: 10.9769/EPJ.2014.6.2.NO
  14. Hodge, P. M., & Jurgens, C. Y. (2011). A pilot study of the effects of Emotional Freedom Techniques in psoriasis. *Energy Psychology: Theory, Research, and Treatment*, 3(2), 13–24. doi: 10.9769/EPJ.2011.3.2.PMH.CYJ
  15. Diepold, J. H., & Goldstein, D. (2008). Thought Field Therapy and qEEG changes in the treatment of trauma: A case study. *Traumatology*, 15(1), 85-93. doi: 10.1177/1534765608325304
  16. Stapleton, P., Sheldon, T., & Porter, B. (2012b). Practical Application of Emotional Freedom Techniques for Food Cravings. *The International Journal of Healing and Caring*, 12(3), 1-9. Retrieved from [http://www98.griffith.edu.au/dspace/bitstream/handle/10072/52756/82986\\_1.pdf?sequence=1](http://www98.griffith.edu.au/dspace/bitstream/handle/10072/52756/82986_1.pdf?sequence=1)
  17. Brattberg, G. (2008). Self-administered EFT (Emotional Freedom Techniques) in Individuals with Fibromyalgia: A Randomized Trial. *Integrative Medicine*, 7(4). Retrieved from [http://www.varkstaden.se/pdf\\_filer/EFT\\_article.pdf](http://www.varkstaden.se/pdf_filer/EFT_article.pdf)

18. Reference withheld to preserve anonymity
19. Guest, G., Namey, E., & Mitchell, M. (2013). *Collecting Qualitative Data: A Field Manual for Applied Research*. London: Sage Publications Limited.
20. Von Glasersfeld, E. (1995). A constructivist approach to teaching. In L. Steffe & J. Gale (Eds.). (1995). *Constructivism in education*, (pp.3-16). New Jersey: Lawrence Erlbaum Associates, Inc.
21. Von Glasersfeld, E. (1984). An introduction to radical constructivism. In P. Watzlawick, *The Invented Reality*, (pp.17-40). New York: W.W. Norton & Company.
22. Von Glasersfeld, E. (1989). Constructivism in education. In T. Husen & N. Postlewaite (Eds.), *International Encyclopedia of Education [Suppl.]*, (pp.162-163). Oxford, England: Pergamon Press.
23. Schwandt, T. (2007). *The SAGE Dictionary of Qualitative Inquiry*, SAGE Publications, Thousand Oaks.
24. Crotty, M. (1998). *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London: SAGE Publications Ltd.
25. Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: SAGE Publications Ltd.
26. Brocki, J., & Wearden, A. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, 21(1), 87-108. doi: 10.1080/14768320500230185
27. Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: SAGE Publications Ltd.
28. Smith, J. (2010). Interpretative Phenomenological Analysis: A Reply to Amedeo Giorgi. *Existential Analysis*, 21(2), 186-192. Retrieved from <http://psycnet.apa.org/psycinfo/2010-15570-001>
29. Smith, J., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J. Smith (Ed), *Qualitative Psychology: A Practical Guide to Research Methods* (2nd edition) (pp. 53-80). London: SAGE Publications Limited.
30. Smith, J., & Eatough, V. (2007). Interpretative Phenomenological Analysis. In Evanthia Lyons and Adrian Coyle (Eds.), *Analysing Qualitative Data in Psychology* (pp. 35-51). London: SAGE Publications Ltd.
31. Liamputtong, P., & Ezzy, D. (2009). *Qualitative Research Methods*. South Melbourne: Oxford University Press.
32. Kitto, S., Chesters, J., & Grbich, C. (2008). Quality in qualitative research. *Medical Journal of Australia*, 188(4), 243-246.



33. Toombs, S. (1988). Illness and the paradigm of lived body. *Theoretical Medicine and Bioethics*, 9(2), 201-226. doi: 10.1007/BF00489413.
34. Kleinman, A. (1988). *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York, NY: Basic Books.
35. Wilberg, P. (2014). *The Illness is the Cure, An introduction to Life Medicine and Life Doctoring - A new existential approach to illness*. CreateSpace Independent Publishing Platform.
36. Ware, C. (1993). Society, Mind and body in chronic fatigue syndrome: an anthropological view. In G. Bock & J. Whelan (Eds.), *Chronic Fatigue Syndrome* (pp. 62-73). Chichester, West Sussex: John Wiley & Sons Ltd.
37. Saltzman, A. (1991). *Downshifting: Reinventing Success on a Slower Track*. New York, NY: Harper Collins Publishers.
38. Chanfrault-Duchet, M. F. (1991). Narrative Structures, Social Models, and Symbolic Representation in the Life Story. In S. B. Gluck & D. Patai (Eds.) *Women's Words: The Feminist Practice of Oral History*. New York, NY: Routledge.
39. Simmons, R. (2009). *The Curse of the Good Girl: Raising Authentic Girls with Courage and Confidence*. New York, NY: The Penguin Press.
40. Zahavi, D. (2014). *Self and Other: Exploring Subjectivity, Empathy, and Shame*. Oxford: Oxford Scholarship Online.
41. Fishbain, D., Rosomoff, H., Cutler, R., & Rosomoff, R. (1995). Secondary Gain Concept: A Review of the Scientific Evidence. *The Clinical Journal of Pain*, 11(1).
42. Davidhizar, R. (1994). The pursuit of illness for secondary gain. *The Healthcare Supervisor*, 13(1), 10-15.
43. Abdelaziz, F.B. (2007). Women's Health and Equity Indicators. *International Journal of Public Health*, 52(1), S1-S2. doi:10.1007/s00038-006-6045-y.

Table 1. Participant Information.

<b>Participant pseudonym</b>	<b>Age</b>	<b>Country of Residence</b>	<b>Gender</b>	<b>Health condition</b>	<b>Overview of EFT utilisation</b>
Alicia	53	Australia	Female	Mast Cell Activation Disorder and Chronic Fatigue Syndrome	Self-administered, With practitioner (primarily online therapy)
Candace	56	Australia	Female	Fibromyalgia and migraines	Primarily self-administered
Cassandra	65	USA	Female	Chronic Fatigue Syndrome and Fibromyalgia	Self-administered, With practitioner
Daisy	46	England	Female	Chronic Fatigue Syndrome	Self-administered, With practitioner
Faith	36	Scotland	Female	Chronic Fatigue Syndrome	Self-administered, With practitioner
Hannah	57	Canada	Female	Crohn's Disease	Primarily self-administered
Kayley	23	England	Female	Chronic Fatigue Syndrome	Self-administered, With practitioner (primarily online therapy)

<b>Participant pseudonym</b>	<b>Age</b>	<b>Country of Residence</b>	<b>Gender</b>	<b>Health condition</b>	<b>Overview of EFT utilisation</b>
Rhea	55	Australia	Female	Arthritis	Self-administered, With practitioner

## Chapter Summary

This chapter addressed my second research objective by presenting findings in relation to chronic disease patients' personal symbolic meanings of their illnesses, as emergent from their use of EFT therapy. This chapter was underpinned by the phenomenon of 'symbolic disease'. The findings presented in this chapter were informed by patient participant interviews. Three themes were presented, namely: 'disease as an embodiment of unresolved emotional issues', 'disease as body's call for time-out and attention', and 'disease as a boundary from other people'. The findings suggest that the use of EFT to assist chronic disease patients make sense of their lived experiences and illness symbology may offer therapeutic value to patients. The next chapter (Chapter 6) will present chronic disease patients' constructions of recovery and address my third research objective.

# Chapter 6: Chronic disease patients' constructions of recovery

---

## Introduction

The previous two results chapters discussed EFT practitioners' experiences of using EFT to support chronic disease healthcare and patients' personal constructions of their diseases as emergent from their use of EFT therapy. The third objective of this study was to explore patients' personal notions of recovery. This chapter presents the study's patient participants' constructions of recovery; hence, only patient participant interviews inform the findings presented in this chapter. Unlike the previous two results chapters which constituted journal articles, this chapter has been presented as an unpublished thesis chapter. The decision to present the current chapter as an unpublished thesis chapter was made due to word limit restrictions of most academic journals. Given the breadth and depth of findings emergent from the interviews in relation to patients' notions of recovery, it was considered more viable to present these findings in an unpublished thesis chapter. Publication of these findings across more than one journal article may be considered at a later stage.

Participants' constructions of recovery were two-faceted; firstly their understanding of recovery as a continuum or a journey, and secondly their markers of recovery, i.e. certain milestones achieved in their recovery journeys, which were perceived to be indicators of significant health improvement. The aforementioned facets are thus presented under two categories, namely, 'constructions of the recovery journey', and 'markers of recovery'. In alignment with the IPA methodology, participants' quotes are interspersed between the researcher's interpretations of the emergent constructions of recovery. The participants' quotes guide the analytical process.

## Constructions of the Recovery Journey

Participants alluded to recovery as a continuum, in that there is always scope for further health improvement. The first section of this chapter explores patient participants' constructions of their recovery journeys, i.e. the nature of this journey, what it involved, and how the participants engaged with these journeys for personal growth. Three main themes emerged from participants' telling of their recovery journeys, namely, 'opening up to the possibility of recovery', 'the spiral path to recovery', and 'creating a new me'.

### *'Opening up' to the possibility of recovery*

Many participants had been ill for long periods of time and discussed the importance of 'opening up' to the possibility of recovery. For example, Chronic Fatigue Syndrome (CFS) patient Fleur, recounted:

I came across EFT because I was looking for ways to help myself recover from chronic fatigue syndrome or ME depending on what you call it. And I was at the point where I was adamant, no matter what, I was getting well. And I threw away all the horror stories of people with ME and stuff, and started reading recovery stories to get some inspiration of what might help me. And, I had never even heard of it [EFT] before, but I was at that point where I was willing to try anything ... I just decided it was time to give myself that permission. So, I just tapped on, "I give myself permission to heal". And, that's what I started tapping on that day ... I think if we give ourselves the permission to be unwell for so long, we wake up, and we count all our ailments, make sure they are all there, present and correct. And then we go on, whatever kind of day we are going to have ... So I think when I came across this concept of actually giving yourself the permission to heal rather than permission to be unwell every day, that kind of made sense to me. (Fleur, CFS)

Fleur's account points to a sense of steadfast determination to improve her health and a commitment to recovering from illness. Her use of EFT with the phrase "I give myself permission to heal" is interesting in that it alludes to maintenance of illness as well as recovering as almost conscious or voluntary actions. Fleur's notion of waking up and ensuring ailments are still present,

implies an apparent ‘self-indulgent self-pity’ at being unwell, which she suggests kept her trapped in the disease state. However, this notion of self-pity may also imply that the patient otherwise has the agency or ability to affect his/her disease outcomes. The idea of giving herself permission to heal is perhaps symbolic of Fleur wanting to break out of this perceived entrapment, viewing an alternate possibility for her life, and metaphorically taking more agency for her disease/health outcomes.

Another CFS patient Cassandra, discussed her view of the possibilities of being well:

When I was still very sick, I wrote my vision statement. What I really realised is each one of us is the possibility for anything ... and it has to do with our perception, and our wishes and our connection to the divine and, we all are possibilities at every moment of our life. And just because I had been so sick didn't mean I couldn't be healthy again. (Cassandra, CFS)

Cassandra's exploration of the term ‘possibility’ presents a subtle yet note-worthy notion. Unlike Fleur, who described ‘possibility’ as an externality that a person can *have* or *view*, Cassandra denotes ‘possibility’ as something that a person *is*. There is also a reference to spirituality in Cassandra's account, whereby she alludes to the importance of a person's connection with oneself, and a spiritual power (‘divine’) to embody a variety of possibilities, and the apparent ability of people to *become* these possibilities at any time they may choose to. Cassandra's use of a ‘vision statement’ for her health is also important. Earlier in her interview, Cassandra had talked about working in a corporate environment where she would periodically have to write or assist other people to write mission and vision statements to guide their professional and business growth. Cassandra's use of this tool for her health, points to her adopting greater agency for her health outcomes almost viewing her body and health improvement as a ‘business’ or a ‘project’; something to be ‘worked on’.

CFS patient Kayley, also discussed her use of EFT to work on the possibility of becoming well:

The doctors were all saying, “you are not going to recover, there are no treatments”. And so, I spent about six months working on the way I perceived my illness, and the world, and a lot of issues, and I got to a place where I already did believe that I could get better. (Kayley, CFS)

Kayley’s quote alludes to her commitment to recovery, despite being told that recovery was not possible. Kayley’s account also points to the long length of time required to believe in the possibility of being well. In Kayley’s account as well, there is a mechanistic notion of ‘working on the body’, i.e. the view of one’s body (or bodily health) as a ‘project’ or ‘product’ that can be improved, if the individual is able to commit to it, and put in enough ‘work’. Another CFS patient Daisy, also discussed the idea of opening up the possibility of being well:

Maybe about 2010, I felt really good and I felt really positive about the possibilities of being well - I was much more open to the possibility of being well. But again there was still kind of a mismatch, it was almost like I wasn't embodying it, it was still quite a lot in my head. It was a very, frightening prospect ... I think it took a while to filter through. It was very much like a, a head state, like a thinking, like I could think what it was going to be like but I couldn't, yeah, it took a little while to embody it. (Daisy, CFS)

Daisy talks about the possibility of being well from a mind-body perspective. Daisy alludes to the manifestation of this possibility as an apparent two-step process, commencing as a thought in the mind, and then filtering down into the body. Her use of the word ‘frightening’ to describe the prospect of being well is also interesting. It is difficult to say what was frightening about the prospect of recovery for Daisy, since some may think that it is the illness that would be considered frightening, and not recovery. Perhaps the idea of recovering was overwhelming, or seemingly insurmountable, which made it frightening. Alternatively, it may be viewed as presenting the notion of the ‘fear of the unknown’, whereby a difficult, albeit *familiar* illness experience, could make envisioning of ‘recovery’ or ‘being well’ frightening. These notions concur with the previous chapter which discussed how an illness can allow a patient to disengage from the world, have the



‘space’ to be with oneself, and a ‘legitimate excuse’ or reason to not participate in socio-economic activities that they did not want to participate in.

For CFS patient Cassandra, the prospect of admitting to feeling well or being on her way to recovery, was also challenging:

My dad had smoked for a long time and then he just stopped one day, and after a week or so people would say to him “oh you quit? That’s wonderful!” And he’d go, “No, I haven’t quit, I just haven’t smoked for four or five days.” You know, after two years, “oh my God you haven’t smoked in two years! It’s wonderful you quit.” “No, I haven’t quit.” You know he didn’t admit he quit for like five years because he never wanted to go back on a promise to himself, you know. And so ... I kind of laughed ... when I finally admitted that I might’ve recovered, because I kind of didn’t want to jinx myself ... or get cocky or overdo or ... think I was better and then get back to being ill again. So I find, I exist by saying, “Yeah I am going to classes. Yeah I started working again,” but you know I didn’t really acknowledge the difference because I was scared about going back again. It’s been a very long haul and it’s scary ... For a long time, I didn’t even want to tell people I was feeling better necessarily. I recognised I was getting stronger, but I wasn’t ready to say I was healthy, because I was scared about that ... It took a long time before and I really haven’t said it until like this year.

(Cassandra, CFS)

Cassandra’s quote paints a poignant narrative of a challenging recovery journey, where getting better may be followed by relapse of illness or symptoms. It appears that not admitting that she was getting healthier, was a way for Cassandra to manage her own expectations about her recovery, and perhaps a means of protecting herself from disappointment in case of future relapses. There is also a notion of the fear or superstition of ‘jinxing’ oneself, in Cassandra’s quote. Indeed, Cassandra’s quote points to a ‘spiral’ nature of the recovery journey, rather than a linear illness to wellness journey. The notion of a spiral path to recovery is discussed in greater detail in the following section.

### *The 'Spiral Path' to recovery*

Participants often described their recovery journeys as at times challenging, windy routes to wellbeing. For example, CFS patient Daisy, recounted:

It was very up and down like I remember one summer I felt great for about six weeks and then, I got ill again. So... I say it definitely wasn't very smooth [laughs] but it was very up and down, and up and down, and up and down... It wasn't a "now I'm well and then I stayed well from that point onward". It'd be like I'd be well for six months and then I might get ill again for six months. (Daisy, CFS)

Daisy's quote alludes to recovery as a continuum, rather than a destination. Her laughter while describing her recovery journey as not a very smooth one, implicates a potentially 'bumpy', or a 'big-dipper/roller coaster' like ride. Her laughter is also interesting in that it appears to hint towards a sense of detachment from the challenging experience of being very unwell. Cassandra also recounted a similar experience of the recovery journey, where small improvements could be followed by setbacks:

I felt like I took one step forward, two steps back all the time. The first year I could tell I was starting to feel better, a little, but not dramatically... It's not a straight line in recovery, at least it wasn't for me. (Cassandra, CFS)

Apart from alluding to the non-linear nature of the recovery journey, Cassandra's quote also suggests that improvements in health may be incremental and gradual. Another participant Alicia, commented that improvements may be tangible and significant on certain occasions, while at other times, incremental such that it may take a long time to notice any substantial improvement in health:

I can feel it improving on a month by month basis ... I have had very pronounced periods [of improvement], and in between that, there has just been a gradual improvement. But... I can actually look back, and say, "Wow, that's a lot better than it was". (Alicia, Mast Cell Activation Disorder)

CFS patient Fleur, also described a similar experience:

It was quite a slow process, obviously it took so long. And there were some ups and downs in that time as well. There were times where I thought, "Oh no, I have got worse again!" But, now I realise mostly those were the healing crises. (Fleur, CFS)

Fleur presents an interesting notion of 'healing crisis'; the idea that there may be a temporary worsening of symptoms before improvements occur (Mackereth, 1999). Fleur's quote also indicates a shift in her view of her illness and health status from being afraid of worsening symptoms to now having an apparent understanding of, or perhaps a new perspective on, her recovery journey and illness experience, alluding to the subjective nature of recovery and illness experiences.

### *Creating a new 'me'*

Participants discussed their endeavours to create a new version of themselves upon having experienced an illness. Participants talked about developing new ways of relating to themselves, their lives, their bodies, and other people post their illness experiences. Participants talked about their recovery journey as a process of creating a 'new version' of themselves following the illness experience, rather than returning to their pre-illness state. Participants' accounts alluded to illness as a potentially transformative experience, a notion which is further explored in this section. Mast Cell Activation Disorder patient Alicia, recounted:

I mean I am never going to be the person I was before I got sick, again. But I feel that my illness, as my GP said to me, has turned me into a new person. (Alicia, Mast Cell Activation Disorder)

CFS patient Kayley, also described a similar experience:

I am not the same person that I was. I am just a completely different person. I can't even describe the change. It's like my... it's like I have been turned inside out. My whole direction of living has sort of reversed. (Kayley, CFS)

Kayley's quote points to illness as a portal for major change in herself as an individual as well as her life. Various other participants also described similar endeavours to create a new version of themselves post their illness experience. For example, Cassandra refers to illness as being a transformative experience:

Maybe my healthy won't look exactly like it did before, but that doesn't mean I can't be healthy and be engaged in life and be happy and connected in all of that. So I mean I, you know because always you think about, "oh well I'll go back to the way I was", but you can never do that because having whatever disease you have changes you. It changes how you think, how you see yourself, how you see the world, and hopefully for good, but it changes you, you can't go back into life how you did it before because you're not the same any more. (Cassandra, CFS)

Cassandra's quote suggests a re-adjustment of expectations for what recovery from illness might look like and an ability to find a new version of 'healthy' post illness. There is a sense that while this new version of 'healthy' may represent a step down from pre-illness health, it may still be possible to lead a functional and fulfilling life and that positive change in a person's outlook towards oneself, life, and the world is possible. CFS patient Daisy, also described her journey of having to readjust her expectations of what recovery might look like:

When I was younger I was determined I was gonna find the cure for chronic fatigue. I would be completely well again. And then I think that when you keep, kind of, being battered down, you don't find this cure or this thing that seems to be helping everyone else, it really takes the edge off your expectations about life or what you can achieve ... It's kind of coming out the other end, really having to readjust your way of thinking about yourself and the world and, people. (Daisy, CFS)

Daisy's quote points to the notion of a 'relentless search' for the ultimate 'cure' for her disease. Daisy's use of the term 'being battered down' is poignant, and encapsulates the emotional struggle associated with an unsuccessful search for a definitive cure, pointing perhaps to a somewhat morbid feeling of defeat. It also perhaps suggests a sense of envy for others who may appear to have found the cure for their illnesses. Subsequently, the phrase 'coming out the other end' seems

to portray a ‘maturing’ of the idea of recovery with time. Additionally, there is a sense of the burden of the expectations reducing once an acceptance of the situation is achieved. Participants described various facets of *change* in their ways of relating with others and themselves, and their outlook on life. The current theme is therefore further examined in three sub-themes namely, ‘a new way of relating with myself and my life’, ‘a new way of relating with my body’, and ‘a new way of relating with other people’.

### *A new way of relating with myself and my life*

Participants suggested that as part of their recovery journeys, they developed new ways of seeing themselves and their lives. For example, CFS patient Kayley, talked about an improvement in her ability to deal with difficult circumstances:

I have sort of got this new belief system where everything is okay, even when things are not okay, everything is okay, and I will get through it. And, I have always managed to get through it. So, I *will* get through it. It is just sort of this belief, this knowledge that everything is okay, so that I can handle anything that happens, in a much more sensible way, in a much more healthy way. (Kayley, CFS)

Kayley’s quote suggests an improvement in her ability to maintain composure in difficult circumstances. There is an oxymoron in Kayley’s quote, wherein she says that “even when things are not okay, everything is okay”. This expression alludes to a certain detachment from life’s problems, an equanimity, perhaps a ‘Zen’ perspective on life. Kayley’s quote also points to a sense of self-confidence, and self-belief in her ability to deal with different and difficult life situations. Some participants indicated that their illness became a portal for change in their lives and led them to re-evaluate their life choices, habits, and ways of being. For example, another CFS patient Fleur, recounted:

Even though having suffered with the CFS, that was horrendous, I am actually grateful for it, because I was just surviving before. I was literally surviving, and that was all. And now, I feel like I am thriving. And it has taught me so much about life because before well, I think, we all think that you need to

just get up, go to work, have 2.4 children ... this ideal of you know earning money, and having a nice car, and doing all this stuff, that actually most of us are not happy doing ... So ... having the illness has... it really changed what I thought about life, what I thought about myself. What I want in life... so and that's why I help other people now as well because, I don't think life is just for surviving. I think life is for thriving. And I think it is important to live in harmony with ourselves, and each other, and the planet and things like that. (Fleur, CFS)

Fleur alludes to her illness experience as a 'teacher'. She appears to have undergone a transformation in her outlook towards her life. Fleur's quote indicates that she underwent a powerful process of introspection, which involved questioning of what may be considered a 'normal' or 'ideal' way of living life. Fleur's use of the expression '2.4 children' has a somewhat sarcastic undertone, and solidifies her apparent rejection of social constructions or norms that people may accept often unconsciously, without introspecting if they may have desires different from the 'norm' of getting a job, starting a family, or owning material possessions. Another participant Daisy, also described the transformation in her outlook towards, and perceptions of her life:

I suppose just being a lot happier, with going... it's funny, if I go slow and do things at my own pace, I seem to be meeting other people who are doing that as well and it's usually quite interesting people; artists or other practitioners doing interesting things. Yeah I just, I just don't feel this need to do things. It's weird I do see life more as a journey where every day is equally as important as before. I used to be so goal-oriented, I always had a goal that I was getting to. I'm definitely not like that anymore. And ... that seems like a very natural process. The way I was doing it was too exhausting. It just seems like it's evolved from Tapping and just doing things a bit differently. (Daisy, CFS)

Daisy acknowledges the perceived unsustainable nature of her previous approach to living life and doing things. Daisy also points to a synchronicity which appears to align with her newfound philosophy towards life and support her new ways of doing things, for example, meeting likeminded people. Daisy's expression 'doing things at my own pace' is also noteworthy in that it

alludes to a divorce from the ‘rat-race’ that she may have previously felt a part of. She suggests that she now leads her life based on what she personally holds important and useful for her own life, health and wellbeing, detached from any apparent societal norms. Daisy also appears to imply that her current ways of doing things are more ‘natural’, as opposed to a previously forced or contrived way of living, driven by goals, rather than by the motivation to lead a meaningful life. Another CFS patient Cassandra, also talked about developing a new ‘pace’ of doing things:

I know that I have a different pace ... I can’t do it like I used to do, but you know that’s okay. I still, I actually feel strong and I’m energetic. (Cassandra, CFS)

Cassandra’s quote points to an acceptance of her post-illness ‘pace’ which is slower than the pace she had before her illness set in. She appears to have undergone an adjustment of expectations that she has of herself, and her overall health, and come to an acceptable state of physical health, where she finds herself to be ‘strong’ and ‘energetic’.

As illustrated by the previous quotes, patient participants often spoke about developing new ways of functioning; adjusting their expectations of life, themselves and their health. For example, Mast Cell Activation Disorder patient Alicia, noted:

Really getting to these core beliefs and understanding my mind, that has been key for me. And, I think ultimately, forgiveness and compassion - not only for others, but for myself. (Alicia, Mast Cell Activation Disorder)

Alicia’s quote points to the importance of self-compassion and compassion for others in her recovery journey. She also alludes to the ‘mind-body’ connection, and the significance of becoming more aware of her mind and limiting beliefs for her recovery.

### *A new way of relating with my body*

Patients described their use of EFT to re-connect with their physical bodies, and develop greater appreciation for their physical bodies, as part of their recovery journeys. For example:

Before I was ill, I disliked my body. And then when I was ill, all the time I was like, "God, I can't do this, and this body doesn't work". And you are really very nasty to your body, which is going to make it very hard for you to be in full health. And one of the things I realised, one day, I wasn't really appreciative of my body. So, I just did some Tapping for thanking my body for doing everything that it had done for me. Thanking it for protecting me, because that's what it was trying to do ... And that was a massive shift. (Fleur, CFS)

Fleur talks about a longstanding pattern of being critical towards her body. In her interview, Fleur had earlier recounted some experiences of physical and sexual abuse that she had faced when younger, which had led her to dislike her body. Fleur's changed relationship with her body is evident from her language, i.e. from previously referring to her body almost as a 'machine' or 'piece of equipment' that did not work like it was supposed to, she moves to later viewing her body with appreciation and gratitude. Fleur's use of the expression 'thanking my body for everything it had done for me' also shows Fleur's recognition of her body's value, ability to function, and undertake various tasks. Her perspective of her body 'protecting' her through the illness, is also interesting, and was discussed in greater detail in the previous chapter where Fleur had described her illness as a *distraction* from thinking about the abuse.

Arthritis patient Rhea, also described her struggles with physical symptoms and times when her body was unable to perform to her expectations:

I don't know about complete recovery, but my focus completely changed. The perception had changed. Before, I was constantly, "oh no, it's hurting, why is it hurting?" ... Take the pill, or go to the physio, or whatever because I was focused on it. Even later on, and after my knees were better and I could walk, was the fact that I couldn't do yoga, and couldn't bend. And that brought the frustration back, and rather than relaxing, it made me more tense. So, I actually do EFT ... during my



yoga poses to release whatever is in that area. And that really helped me tremendously as well. So, now it doesn't matter, if I can't do *vajrasana*. [laughs]. (Rhea, Arthritis)

Rhea's quote indicates an adjustment of her expectations of her body, and an acceptance of her body's limitations. Rhea describes her previous pattern of focusing on the body's limitations and limited acknowledgement or appreciation of improvements, e.g. being able to walk, followed by an almost frantic search for the solution to her physical symptoms. Her quote also alludes to an interesting use of EFT, i.e. its use during *yoga*. Rhea's laughter at her inability to do certain yoga poses is also note-worthy and suggests that certain limitations of her body perhaps do not worry her as much anymore. CFS patient Cassandra, also described her readjustment insofar as her bodily health:

I have been trying to build my body up to get the endurance back. You know, I'll never have the same endurance as a 40-year-old, as I did. But I am trying to, you know there's no reason I can't, you know some 60 year olds run marathons. (Cassandra, CFS)

Cassandra appears to have a 'realistic' yet positive expectation for her recovery journey. While she acknowledges that she may not return to her pre-illness bodily health, she appears hopeful about being healthy, and indicates that re-building her health post her illness is an incremental process.

Mast cell activation disorder patient Alicia, introduced another facet of connecting with her body, when she said that "truly listening to my body and understanding, what it needs" has been a large part of her recovery journey. Alicia described what may be perceived as an 'intuitive connection' with her body, as if the physical body can send Alicia 'messages' as to what it needs. Alicia's quote also appears to have the notion of the personification of the physical body, which has been discussed in the previous chapter. Alicia alluded to her ability to have some form of communication with the physical body, and act on the body's messages to facilitate health improvement.

### *A new way of relating with other people*

The previous sub-themes described participants' altered ways of relating with themselves, their lives, and their bodies. Participants also described the changes in their ways of relating with other people. One of the key aspects of this change was the balance between giving and receiving. For example, CFS patient Kayley, discussed her long-standing pattern of helping other people at the expense of her own well-being, and always going above and beyond her 'call of duty' to support others, which had taken a toll on her own health. Kayley's story was also discussed in detail in the previous chapter. As part of her recovery journey, Kayley made a change in her approach to relating with and helping people:

I don't help people unless it feels good to me. And, I don't feel guilty about it that I have to look after myself first. And, I don't do anything that feels bad to me. I am very good at checking what feels good and what feels bad to me. And I keep my boundaries and I don't give in. If something is important to me, then I give in. I try not to give too much of myself. I try not to do anything that will make me feel resentful afterwards. (Kayley, CFS)

Kayley's quote points to an improved sense of self-awareness of her own emotions, feelings, and needs. Her quote also contains the notion of 'picking one's battles', whereby she says that she is willing to stretch herself where the circumstance in question feels important to her. Kayley's quote also suggests that she has become more protective of her own personal resources, as illustrated by her use of the expression 'not giving too much of myself'. Cassandra also discussed her new ways of relating with people, in particular, becoming more comfortable with receiving help:

I'd never been a sickly person and hated that people were seeing me this sick all the time. And I hated that I felt bad but, there's always only ever so much you can do at such a pace you know ... So it was, it was a revelation; it really struck me like to the core ... I guess one of the things I learned was ... how to accept people's gifts like ... I'm much more a giver than a receiver ... But to allow them to do something for you ... that was a very humbling experience. (Cassandra, CFS)

Cassandra's quote speaks of her former personality that was used to being in charge, in control, and able to help other people in their times of need. It appears that Cassandra would be more at ease giving to people rather than receiving from them. Cassandra's quote reflects a sense of acceptance of her body's limitations owing to ill health, and a resultant openness to receiving help and support. Her use of the term 'humbling experience' to describe her feelings on accepting help and support from people, also illustrates the magnitude of discomfort felt by her while accepting help. Crohn's Disease patient Hannah, presented another facet of the ways in which an illness experience affected her ways of relating with others:

You would know what it is like to be sick and in pain and that you can understand and have compassion for others. (Hannah, Crohn's Disease)

Hannah's quote contains the narrative of hardship making one a better person. Hannah points to an increased sense of empathy and consideration for other people's suffering. While participants described in great depth how their illness experiences changed their ways of being, and doing things, Kayley interestingly, also described how other people in her life also benefited from her recovery journey:

What is very very interesting and amazing to see is how my family has changed from my illness and ... more from my recovery I think because the whole family was very dysfunctional. One of my older brothers, and he went through similar things with me. He had panic attacks, and was very anxious. And he had a lot of trauma. And, he was very, not into psychological type things and... I got him into more of the emotional side of stuff and I supported him quite a lot. And he is now becoming very into this sort of stuff as well. And he has completely changed as a person. And my elder sister, she loves like this change that I have gone through, and she is very inspired by watching me grow and change, and face my fears and face things I found difficult. So, she always says she looks up to me, which is a bit weird [laughs] ... As a kid, she didn't like me ... She has also become more aware of, I think, emotional type things that I have taught her. And then, my parents have changed like, from the whole situation. So it has been like a healing journey for the whole family, not just with me. I have

sort of been the centre of it, but there has been a lot of change around me. So, yeah all my relationships have changed with each other. And yeah, so, it's brilliant. (Kayley, CFS)

In the previous quote, Hannah described how her illness experience enhanced her ability to have compassion and understanding for other people's pain. Kayley's quote reflects a similar ability to support a sibling undergoing challenging times after having struggled with a difficult illness experience herself. Kayley's journey may also be considered as an apt representation of 'post-traumatic growth' (Hefferon, Grealy & Mutrie, 2009). This quote is a powerful illustration of the personal growth achieved during a recovery journey, particularly well demonstrated through Kayley's ability to elicit respect from older siblings. Kayley's account portrays her illness and recovery journey as being transformative for her entire family. Her experience speaks of the intricately woven familial dynamics, and how one person's circumstances and personal healing work can impact the lives of other family members.

### **'Markers of Recovery'**

The previous theme, 'Constructions of the Recovery Journey' described how participants viewed their journeys from illness to health. While the participants saw recovery as a continuum more than as a destination, they identified certain markers of recovery. These markers of recovery meant to the participants that their health had significantly improved. These markers meant for the participants that they had reached a certain milestone in their recovery journeys where they could consider themselves to be reasonably healthy and well. The present theme explores these markers of recovery.

### *Improved Emotional State(s)*

As has been discussed in previous chapters, chronic physical illnesses can have significant psychological health impacts. Patient participants described an improvement in their emotional state(s) as being an important marker of recovery from chronic illness. Examples of improved emotional state included improvements in perceived anxiety levels, peace of mind, happiness, and locus of control. This sub-theme examines participants' perceived improvements in their emotional states. CFS patient Daisy, recounted:

I'd become very, very anxious and ... it was like a norm so I just hadn't noticed how anxious I was or how worried I was about things ... I'd been having panic attacks but I didn't know they were panic attacks. I didn't have enough sense of... not being depressed to kind of know how depressed I was ... I suddenly had the realisation one day that I hadn't been anxious, for about three months and it was like, "Oh!" Now that was a massive shift but I hadn't actually noticed it happen. It was just like "Oh, I'm not anxious any more". (Daisy, CFS)

Daisy's quote indicates that emotional issues can often go unnoticed or undiagnosed. Furthermore, patients may not be able to put a name to their emotional symptoms or recognise the existence of an issue, such as panic attacks in Daisy's case. Additionally, Daisy's claim that she had not noticed her anxiety levels drop also points to a subtle and gradual process of improvement in her psychological health. Mast Cell Activation Disorder patient Alicia, described greater peace of mind, as an important marker of recovery for her:

Recovery for me means peace of mind, which I feel I have pretty much achieved. I wouldn't say I have peace of mind about what happened 365 days a year, but, I probably would have 360 days a year. That is about as good as it is going to get ... But, what I would also like in addition to peace of mind, is ... I would describe as peace of body. But, I see it as, recovery to me, to sort of be a sense of peace. (Alicia, Mast Cell Activation Disorder)

Alicia's quote suggests that that she has reached a certain stability in her emotional health and has come to an adequate level of acceptance of her health struggles and past experiences. Additionally,

Alicia's reference to 'peace of body' is noteworthy, and may be thought to imply that emotions can also be felt in the body. This embodied nature of emotions was also discussed in the previous chapter in a different light, where participants talked about the embodiment and manifestation of negative emotions (e.g. fear, anger) as illness or physical symptoms. Here, Alicia alludes to the embodiment of a positive emotional state, i.e. 'a sense of peace'. Arthritis patient Rhea also talked about improved overall happiness:

The outlook changed completely. And the focus changed, and once you know, I become happier, then I see the world differently. (Rhea, Arthritis)

Rhea had talked about changing her focus and outlook towards herself and her body, which was also discussed under the theme 'creating a new me'. Here Rhea talks about the relationship between being happier and having a different outlook on the world. Whether changing her focus, and perspective on the world made Rhea happier or becoming happier changed her perspective on the world, is unclear and reflects the chicken and egg notion of 'what came first?' However, happiness level (or even a person's overall emotional state) can be seen to be inextricably linked with a person's focus and world view, perhaps constituting a virtuous circle between the two.

In discussing their emotional states, participants also talked about the importance of having tools for self-management of negative emotions, in this case, EFT. For example, fibromyalgia patient Candace, recounted:

You can reverse the process of panic and fear ... Instead of going downward spiral, you can actually... in that moment [of pain], you have got choice. And, when you continue Tapping, and you stay with whatever is going on in you ... you have more clarity, and the answers ... and that's why it is so powerful. (Candace, Fibromyalgia)

Candace's reference to the idea of having a choice in a moment of pain and distress is quite powerful, and speaks of the use of EFT for self-care. Having a tool that patients can use to self-

manage symptoms can provide patients greater locus of control over their wellbeing. Another noteworthy aspect of Candace's quote is the concept of 'staying with whatever is going on', in that, rather than avoiding or resisting an emotional or physical symptom, a patient may be able to face it and tap through it to garner some relief. CFS patient Kayley, also discussed her use of EFT to address feelings of 'unsafety' and insecurity:

With EFT, I feel a lot more empowered. There is always something there to fall back on. So, I don't feel unsafe any more. I feel secure and safe. There are things that can happen which will make me feel unsafe, but then I always have some way of dealing with that, and reminding myself that I am okay. That I will be okay. (Kayley, CFS)

In her interview, Kayley described a longstanding pattern of feeling unsafe and insecure and her work addressing these feelings via EFT therapy. Kayley's account also indicates that she considers herself better equipped to deal with emotionally challenging circumstances. This quote, like Candace's previous quote, also speaks of the use of EFT for self-care and self-management of emotional wellbeing.

### *No longer restricted by illness*

As the participants described, one of the markers of recovery was that they no longer felt restricted by their illnesses, inasmuch as their ability to engage with life and undertake day-to-day activities was improved. While patient participants acknowledged that there was scope for further progress (as per the notion of recovery being a continuum), they found the improvement in their health to be palpable enough that their lives were no longer controlled or limited by their illnesses. Mast Cell Activation Disorder patient Alicia, described this as "the ability to expend energy on more things". Participants appeared to value the ability to undertake a variety of tasks and engage in different activities despite their illness, something that may not necessarily have been possible previously. CFS patient Kayley, described:

I could take a job, I could do all I want, and I am not limited at all, like I used to be. And, so... that's probably something. It took me about two years of EFT to get to this point. But, I have still got more work to do. I am not finished yet. (Kayley, CFS)

Kayley's quote is an apt illustration of recovery being both a continuum, as well as a milestone. Furthermore, her quote also relates to a previously discussed view of the body as a 'project' that can be improved, if an individual is committed to recovery, and puts in enough effort for his/her health improvement. Another CFS patient Cassandra, described how she is now able to engage more with life:

I can walk several miles, I can ride my bike, I could garden, in addition to working, you know. I can do several, I can do, and I don't have to cancel things. I mean it's part of what I really love that if I make plans with friends, I can keep them. We *can* go to a movie ... I think my friends enjoy counting on me too because, I mean they understood before but it's also a bummer. (Cassandra, CFS)

During her interview, Cassandra had described how having CFS impacted her ability to sustain commitments for social engagements. She could never predict how she was going to feel on a certain day in the future, and would often have to cancel plans which would be disappointing for both herself, and the other party. Cassandra's emphasis on '*can go to a movie*' powerfully demonstrates the impact of her illness on her life engagement. Undertaking everyday activities such as meeting friends or watching a movie that an otherwise healthy person may take for granted, appears to have been challenging for Cassandra in the past. On one hand, her quote aptly sheds light on the psychosocial challenges that may come with an illness; on the other hand, her repeated use of the expression 'can' is illustrative of the various activities she is now able to partake in.

Participants acknowledged that symptoms can still recur and impact their current wellbeing. However, participants claimed to feel better equipped to deal with arising problems during those recurrences, as Cassandra noted:



I will get the pain again, from time to time. I actually had a headache two days ago, it's really funny, isn't it? And, but it never restricts me in anything. I am not scared of it ... It's a bit of a nuisance sometimes, and I think, "okay, if it gets worse, I can just tap through it", and it goes away ... Not only that I lead like a normal life, but ... I can do strenuous physical work ... I don't even know if I like the word 'control', but it's like, "Wow!" ... "I can deal with this. I was scared of this". Yeah, it had control over my life. It puts stop to my movements, my physical movements, and I can actually deal with this. (Candace, Fibromyalgia and migraines)

Candace's quote illustrates the progress in her recovery journey from her illness restricting her physical movements and limiting her life engagement, to now being an occasional 'nuisance' in her overall 'normal life' that she has the tools to deal with. The notion of the 'normal life' is noteworthy, and implies her ability to undertake day to day activities, without being limited by an illness. Candace's quote also reflects the use of EFT for self-care. It appears that she has a greater perceived locus of control over her illness and symptoms. Arthritis patient Rhea, also recounted a similar experience:

I was not able to do like, even, carry on the normal duties in the house without having pain, and having to sit down, because it was so bad. I had to sit every hour or so. And I had to succumb to the fact that my body was going through something. So, every now and then, I had to sleep, or sit down. So, for me, it meant you know, just freely being able to walk and do things. Not run a marathon, but at least be able to walk around the block ... For me, to feel free from this chronic pain, that's constantly there. (Rhea, Arthritis)

Rhea's quote suggests that while she accepts that her body still has certain limitations, i.e. her understanding that she may not be able to run a marathon as yet, she is able to undertake simpler movements, like walking, and doing chores. Rhea's quote also points to the significance of having relief from chronic symptoms, which can have severe disruptive consequences for a patient's quality of life.

### *Moving beyond survival*

The previous theme explored participants' accounts of not being restricted by an illness and having a sense of normalcy in life, such that they could engage with day to day activities with relative ease. However, participants also spoke about moving beyond simply surviving to engaging with life in more meaningful ways, which might involve pushing their mental and physical boundaries, and challenging themselves. The present theme looks at participants' accounts of 'moving beyond survival'. CFS patient Cassandra, recounted:

I travelled to Paris with my son two years ago. He was teaching in Spain for a year, as an internship for college ... So for his Easter break, he didn't have any plans and I met him in Paris and we had a week in Paris. It was a wonderful thing. And I was really nervous ahead of time, it was the first trip I'd taken since I had had the cancer, a big trip like that ... to be out of the country ... I didn't even know if I could handle that long of a plane ride ... people have trouble doing it when they're healthy much less, you know, and I, and I did it and we had a wonderful time. And in Paris, everybody walks, you take trains and you walk. We walked for miles every day. And, we just had a really fun time ... After that trip was when I finally, to myself, began acknowledging I was healthy again. (Cassandra, CFS)

Cassandra's account provides an encouraging narrative of moving beyond survival. Being able to connect with family while participating in life enhancing activities, such as travelling to a new country, while recovering from a chronic illness exemplifies the progress in her recovery journey beyond mere symptom management. The trip may also be considered to represent a metaphorical 'coming of age' experience in her wellness journey. Another nuance that seems relevant in Cassandra's account of her travels is her immersion in the culture of her travel destination. For example, she recounted that everyone in Paris walks and takes trains, and they 'walked for miles every day', showing that not too many allowances were made to accommodate her illness needs, and Cassandra was able to explore this new city like any other 'normal' healthy tourist.

Participants also described their experiences of challenging themselves to accomplish extraordinary feats:

In 2013, I decided, well yeah, I can climb Kilimanjaro. And, you know, Mahima, when I was looking at some of the dates, so I am clear what I am saying to you, I thought, "oh my God! How courageous I was!" ... To know that I have got that [Fibromyalgia], and to decide ... and to trust. And trust in EFT, and whatever I have learnt, but especially EFT because I was... I thought you know, whatever happens, I will just Tap through it. (Candace, Fibromyalgia)

Candace's description of her decision to climb the highest mountain peak in Africa, Mount Kilimanjaro, while suffering from fibromyalgia, a potentially debilitating illness, appears to have a 'matter of fact' undertone. She says in a straightforward, almost unemotional way, "I decided, well yeah, I can climb Kilimanjaro". This expression reflects almost a dispassionate resolve to accomplish this task perhaps stemming from her belief in herself and her ability to use EFT, a self-management tool, in an event of emotional or physical distress. Candace's faith and trust in EFT as a self-care tool appears potent in this quote, and demonstrates a strong locus of control of her wellbeing even in physically draining situations, i.e. climbing a mountain. Despite starting off with a seemingly impassive declaration of her decision to climb this mountain, retrospectively Candace appears surprised and proud of this accomplishment.

CFS patient Fleur, also described her experience of climbing a mountain:

I decided to walk up what they call in Scotland, a Munro, which is a mountain. And, I decided to walk up one of those, and I thought this would either kill me [laughs] or... it will make me realise I *am* fully well. And I had been doing more exercise up until that point, but nothing like that. And that day, I walked up that mountain. I didn't struggle any more than anyone else that was there. Actually there was one person there that struggled more than me. And, I recovered, I was fine. Like the day after that, I was a bit achy, but you would expect that after climbing a mountain. So, after that, I was absolutely fine, and that was my moment I think, when I thought that ... it's gone. There are moments during the illness, and during your recovery where you can do the odd thing here and there, but being able to walk up a mountain and feel fine two days later, that's definitely, you know, there is no ME [CFS] left then. (Fleur, CFS)

Fleur's account points to a well-considered process of pushing herself to accomplish a remarkable task, with the view to self-assess the extent of her recovery. Her comparison of her ability to climb this mountain with the other climbers in the group also demonstrates her internal process of reflecting on her health status at the time. The other climbers perhaps gave her a point of reference for understanding how far along she had reached in her recovery journey. It appears that while she had been exercising previously, and "doing the odd thing here and there", she needed to take a drastic step to get a perspective on her recovery journey. This is understandable when viewed from the lens of 'the spiral path to recovery', which has been discussed previously in this chapter. This previous theme had illustrated participants' experiences of small improvements in health, being followed by relapses. As such, Fleur's exploration of the improvement in her health status by challenging herself to a physically demanding task, appears congruent with the notion of the spiral journey towards recovery. Additionally, both Candace's and Fleur's accounts presented in this theme also present a powerful metaphor of 'climbing the mountain', i.e. overcoming a seemingly insurmountable, or extremely difficult problem. In figuratively viewing their illnesses as 'mountains', these two women's accounts can be thought to symbolise their journeys to conquering their illnesses.

## **Discussion of themes**

This chapter addressed my third research objective by presenting participants' constructions of recovery as explored through two different but interconnected lenses, namely 'constructions of the recovery journey', and 'markers of recovery'. The present section provides a discussion of the themes emergent from patient participants' accounts in the context of extant literature on the notion of 'recovery'. Among the themes exploring participants' constructions of the recovery journey was the notion of 'opening up to the possibility of recovery'. Participants described their internal processes of becoming open to the idea of recovering from their illnesses. Some

participants even talked about the pursuit of recovery almost as a ‘project’ to work on. For some participants, the prospect of ‘recovering’ was almost overwhelming and possibly even frightening. My study’s participants’ accounts of ‘possibility’ appear related to the idea of ‘hope’ that is very often discussed in recovery literature.

The recovery model proposed by Whitley and Drake (2010) which was discussed in Chapter 2 (Literature Review), includes a component of ‘hope’ under the concept of ‘existential recovery’. Jacobson and Greenley (2001, p. 483) discussed the importance of ‘hope’ and state that “by expanding the realm of the possible, hope lays the groundwork for healing to begin”. According to Jacobson and Greenley (2001), ‘recovery’ may sometimes be conflated with ‘cure’, leading some patients and even health practitioners to refrain from considering the possibility of recovery, due to the fear of holding unrealistic expectations. Jacobson and Greenley (2001) suggested that hope is also important since it can assist patients get through relapses of illness or symptoms. Another emergent theme in this chapter was the notion of the ‘spiral path to recovery’, where minor improvements in health may be followed by relapses. One participant illustrated this theme through her use of the phrase “waiting for the other shoe to drop”, a vernacular expression that implies awaiting an imminent, inevitable and generally undesirable event.

Jacobson and Greenley (2001) also noted the importance of patients learning to manage their symptoms, practising self-care for stress reduction, and generally following a wellness focused lifestyle. Under the theme, ‘creating a new me’, I presented participants’ accounts of adopting new ways of relating with themselves, their bodies, other people, and their lives in general. One of the aspects of participants’ notions of creating a new sense of self involved constructing new versions of what ‘healthy’ meant for them, and often adopting a new relatively ‘slower’ pace of life. Aujoulat, Marcolongo, Bonadiman and Deccache (2008) explored the process of empowerment and agency in chronic illness patients. Aujoulat et al. (2008) suggested that acceptance of illness related

boundaries and restrictions, and surrendering the need to control these illness-driven limitations, is crucial for personal empowerment in patients, where chronic illness may have led to feelings of powerlessness. Aujoulat et al. (2008) referred to the aforementioned relinquishment of control and notion of 'letting go' as being a process of reconciliation of one's identity.

The theme, 'creating a new me', presented the notion of illness being a 'transformative' experience, a portal of change for the patients. Scammell (2002) presented accounts of people with fibromyalgia alluding to chronic illness as a tool for transformation. Various themes emergent in Scammell's (2002) findings in relation to facets of personal transformation, appear compatible with the themes presented in this chapter, e.g. making healthier lifestyle choices, having a positive attitude towards life, having a sense of gratitude, and becoming a self-authority.

Participants' accounts also pointed to certain 'milestones' in their recovery journey, which were personal indicators of significant health improvements for the participants. Jacobson and Greenley (2001) also noted that 'recovery' encompasses both an endpoint which may or not involve a return to 'normalcy', but also a sense of control in the patient, and active engagement in activities to help oneself. The 'endpoint' described by Jacobson and Greenley (2001) may be considered aligned with the 'markers of recovery' explored in this chapter including, 'improved emotional state', 'not feeling restricted by illness', and 'moving beyond survival'. Scammell (2002) presented adoption of a positive outlook, fostering hope, and holding gratitude as being aspects of illness-driven personal transformation. Participants interviewed in the study conducted by Scammell (2002), similar to my study's participants, discussed the importance of having a positive attitude, greater appreciation and gratitude, as markers of personal transformation.

The notion of no longer feeling restricted by illness, as described by my study's participants can be considered akin to the concept of 'locus of control'. Participants' accounts point to a

perceived sense of greater locus of control over their illnesses. Their narratives of being able to engage in socio-economic activities, which some of them could formerly not partake in, also points to an improvement in their quality of life. Participants' narratives such as climbing mountains, or travelling overseas, point to a sense of greater enjoyment of life. The notions of 'moving beyond survival', 'thriving', or 'life enjoyment', following onset of chronic illness, is primarily discussed under the concept of 'post-traumatic growth' in academic literature. For example, Hefferon et al. (2009) synthesised qualitative data on illness related post-traumatic growth. Hefferon et al. (2009) present the following emergent themes on illness-related post-traumatic growth: reappraisal of life and priorities, self-development, existential re-evaluation, and a new awareness of the body, all of which appear analogous to the findings presented in this chapter, and aligned with my research objective, methodological framework, and underpinning literature.

It should be noted that the two themes which explored recovery as firstly, a continuum and secondly, a milestone, are not necessarily divergent when viewed in accordance with a constructivist epistemological position and phenomenological perspective. In Chapter 3 (Methodology), I had presented phenomenological thinker Sartre's view that humans are constantly in the state of 'becoming'; and the constructivist perspective on reality as being a constant active construction and reconstruction undertaken by an individual. As such, the 'milestones' of recovery presented in this chapter may simply be viewed as being contextual markers in the broader, constant and active construction/reconstruction of patients' recovery continuum.

## Chapter Summary

This chapter addressed my third research objective and presented the emergent findings in relation to patients' personal notions of recovery. This chapter was informed by the interviews of patient participants. The findings presented in this chapter encompassed two main themes, namely, 'constructions of the recovery journey' and 'markers of recovery'. On one hand, participants described their understanding of recovery as a continuum or a journey, which was explored under the theme, 'constructions of the recovery journey'. On the other hand, participants alluded to certain milestones achieved in their recovery journeys, which were perceived to be indicators of significant health improvement; these milestones were explored under the theme, 'markers of recovery'. The next chapter (Chapter 7) will address my final research objective, and explore patients' and practitioners' EFT experiences in the context of the WHO determinants of health.



# Chapter 7: Supporting Chronic Disease Healthcare through Remote Emotional Freedom Techniques (EFT) Treatment and Self-care: An Evaluation using the WHO Determinants of Health

---

## Introduction

The previous chapter presented findings in relation to the patient participants' constructions of recovery. The current chapter, which is also the final results chapter in this thesis, presents findings in relation to my fourth research objective, to explore:

*The usefulness of telephone/internet delivery and self-administration of EFT in the context of the WHO determinants of health.*

Both practitioner and patient participant interviews inform this chapter. As such, the findings presented in this chapter include a combination of both patients' and practitioners' perspectives. This chapter comprises a journal article whose reference is provided in the following section. Due to the journal's requirements, third person voice has been used in this chapter. Four themes are presented in this chapter, namely: 'practitioner and client experiences of online EFT therapy', 'experiences of telephone EFT therapy', 'experiences of online support groups', and 'the use of EFT for self-care'. As previously mentioned, this research study is underpinned by the biopsychosocial model of health. The current chapter endeavours to explore the social dimension of users' experiences of EFT. This chapter evaluates users' experiences of EFT in light of select WHO determinants of health, namely social support, individual behaviours and coping (covered under the determinant of 'genetics'), health services, and physical environment.

## Chapter Contents: Journal article

This chapter comprises the following journal article:

Kalla, M. (2016). Supporting Chronic Disease Healthcare through Remote Emotional Freedom Techniques (EFT) Treatment and Self-care: An Evaluation Using the WHO Determinants of Health. *Energy Psychology: Theory, Research and Method*, 8(1), 55-66. doi: 10.9769/EPJ.2016.8.1.MK.

A copy of the aforementioned journal article is included in the thesis as follows. I have not renumbered the pages of the journal article with the view to include the publication in its original form.

# Supporting Chronic Disease Healthcare Through Remote Emotional Freedom Techniques (EFT) Treatment and Self-care: An Evaluation Using the WHO Determinants of Health

*Mahima Kalla, Monash University, Australia*

## Abstract

The United Nations World Health Organization (WHO) defines determinants that influence people's health, such as income, education, social support, physical environment, access to health services, personal behaviors, and gender. This study explores delivery of a therapeutic intervention called Emotional Freedom Techniques (EFT) and self-administration of EFT in chronic disease patients from the perspective of the WHO determinants of health. Sixteen participants, including eight EFT practitioners and eight chronic disease patients, described their experiences of EFT in semi-structured interviews. Data was analyzed using Interpretative Phenomenological Analysis (IPA) methodology. Four major themes were identified: practitioner and client experiences of online EFT therapy, experiences of telephone EFT

therapy, experiences in online support groups, and the use of EFT for self-care. Participant accounts illustrated EFT's value in alleviating barriers to access to health services and facilitating self-care in chronic disease patients. Online and telephone delivery of EFT offered a useful alternative for residents of remote and rural areas without access to mental health services. EFT is effective in groups using online videoconferencing platforms to provide a social support network. Additionally, EFT is favored by the study's participants for self-care, maintaining positive mood, and for general well-being.

**Keywords:** Emotional Freedom Techniques (EFT), telemental health applications, WHO determinants of health, self-care, remote consultation

**Mahima Kalla** is a PhD student in the School of Rural Health at Monash University, Australia. She is researching chronic disease patients' and EFT practitioners' use of EFT for supporting chronic disease healthcare. **Acknowledgments:** Thank you to all the participants of this study. **Disclosure:** The author declares no conflict of interest.

## The WHO Determinants of Health

The United Nations World Health Organization (WHO) evaluates factors that collectively impact the health and well-being of people and communities. A person's health is determined by his or her personal circumstances as well as the physical environment. WHO calls these factors "determinants of health" and characterizes them into three broad categories, namely social and economic environment, physical environment, and individual characteristics and behaviors (WHO, 2016). WHO acknowledges that many determinants of an individual's health may be beyond

his or her control. Consequently, "blaming" an individual for his or her ill health may not only be unfair, but also unproductive (WHO, 2016).

In assessing the impacts of a proposed policy or program, WHO and its affiliated organizations may utilize a tool known as the Health Impact Assessment (HIA). An HIA assists decision-makers in evaluating the potential of a proposed initiative's impacts on a population's health. The determinants of health are often taken into account in these health impact assessments while evaluating the prospective benefits of a proposed health initiative.

WHO further elaborates seven determinants of health, as follows (WHO, 2016):

1. Income and social status: higher income/social status is associated with greater health. The larger the gap between the richest and poorest in a population, the greater will be the health disparity.

2. Education: Lack of education is linked with poorer health, stress, and low self-confidence.
3. Physical environment: This includes access to clean water and air, safe and healthy working conditions, and the availability of infrastructure such as roads.
4. Social support networks: Support from family, friends, and the broader community is associated with greater health. This determinant also encompasses cultural aspects such as traditions and customs, and familial and community beliefs.
5. Genetics: This determinant not only includes genetic inheritance, but also personal behaviors, coping mechanisms, lifestyle habits, and general ability to deal with life's stressors and challenges.
6. Health services: Access to health services plays a major role in prevention and treatment of disease.
7. Gender: Men and women experience different illnesses, and at different ages.

The present article reviews patients' and practitioners' experiences of using Emotional Freedom Techniques (EFT) for supporting chronic disease healthcare from the lens of the WHO determinants of health; primarily, social support networks, genetics (mainly, individual behaviors and coping/dealing), health services, and physical environment (mainly, access to technological infrastructure).

## Emotional Freedom Techniques (EFT)

Emotional Freedom Techniques (EFT), also known as "tapping," combines Chinese acupuncture (acupressure) and Western psychotherapeutic principles. It is described in a manual that has been available since the inception of the method in 1995, leading to uniformity of research and practice (Craig & Fowlie, 1995; Church, 2013b). Over 100 studies and review articles have appeared in peer-reviewed medical and psychology journals, and a current research bibliography is available at [Research.EFTuniverse.com](http://Research.EFTuniverse.com). Meta-analyses of clinical trials have found a large treatment effect for anxiety, depression, and posttraumatic stress disorder (PTSD; Clond, 2016; Nelms & Castel, 2016; Sebastian & Nelms, 2016).

When administering EFT, a person gently taps on certain acupuncture points on the face and

upper body while being psychologically exposed to an emotional trigger (Boath, Stewart, & Carryer, 2012). The acupoint stimulation is believed to send a signal to the limbic system and reduce hyperarousal (Feinstein, 2010). Studies indicate that EFT may be decreasing the activity in the amygdala, which is responsible for signaling a threat response to perceived dangers to the autonomic nervous system (Harper, 2012). The therapeutic effects produced by EFT are suggested to result from the synergy between the somatic acupoint stimulation and cognitive strategies (Stapleton, Sheldon, & Porter 2012). During the tapping process, while focusing on an emotional trigger, subjects may also voice statements of self-acceptance. Similar to other interventions such as cognitive behavioral therapy (CBT) and mindfulness, EFT also relies on the premise that acceptance of, rather than resistance to, a particular condition can reduce suffering (Brattberg, 2008).

EFT can be administered by practitioners via telephone, as well as online services such as Skype, FaceTime, and Google Hangouts. Provision of mental healthcare interventions via such telecommunication technologies is often referred to as "telemental health" (TMH; Hailey, Roine, & Ohinmaa, 2008). Provision of mental healthcare from a distance can be a useful means of overcoming geographical obstacles to access of mental healthcare (Hailey et al., 2008). Therefore, delivery of EFT via TMH applications may have implications for health determinants, such as improved access to health services. A randomized controlled trial in which veterans received EFT through either phone or office sessions found that six sessions of EFT remediated PTSD in 67% of participants, though in-person treatment produced significantly better results with a 91% success rate (Hartung & Stein, 2012).

Additionally, EFT is a technique that can be self-administered by users for ongoing management of their well-being. EFT has been found to be safe; no adverse events have been reported in the studies described in review articles of the method (Church, 2013a; Feinstein & Church, 2010). Clinicians usually report a rapid diminution of client emotional distress during tapping sessions (Church & Feinstein, 2013). As such, the self-administration of EFT fits the criteria for the WHO health determinant entitled "genetics," supporting healthy personal behaviors, adaptive

coping mechanisms, health-promoting lifestyle habits, and general ability to deal with life's stressors and challenges.

## Study Aim

The present study was undertaken as part of the author's doctoral study qualitatively exploring patients' and practitioners' experiences of using EFT for supporting chronic disease healthcare. Various themes emerged from the data. The current article presents themes surrounding chronic disease patients' and EFT practitioners' use of remote EFT therapy (delivered online or over the telephone) and self-administration of EFT. The article evaluates the emergent themes in the context of the WHO determinants of health.

## Methods

Furthering the understanding of illness narratives and patient experiences is crucial for expanding the knowledge of diseases and interventions, and informing healthcare programs and policies. The provision of effective healthcare to patients is not possible without a profound appreciation of both patients' and health practitioners' personal experiences and perspectives (Coulter, 2013). As such, it was decided that the voices of both chronic disease patients and EFT practitioners would be used to inform the research question.

Interpretative Phenomenological Analysis (IPA) is a methodology that allows for experiential qualitative research in psychology (Smith, 2010). IPA has been widely used in studies exploring patients' and health practitioners' experiences of illnesses and interventions. IPA is phenomenological, in that it allows for the study of lived experience, and hermeneutic, in that it involves interpretation of participants' experiences by the researcher. IPA also has an idiographic focus, that is, detailed investigation of unique cases and individuals, which means that a small number of participants is required, even appropriate.

As such, IPA was deemed a suitable methodology for the present study.

## Sampling and Recruitment

The study was approved by the Monash University Human Research Ethics Committee prior to commencement (CF14/3800–2014001991).

Sixteen participants were interviewed for this study, comprising eight EFT practitioners and eight adults with chronic diseases who had used EFT in their healthcare regimes. Practitioners were required to be certified through professional bodies such as the Association for the Advancement of Meridian Energy Techniques (AAMET), EFT Universe, or the Association for Comprehensive Energy Psychology (ACEP); have at least 4 years' experience practicing EFT professionally; and have treated at least three client cases of chronic physical illnesses. Patient participants needed to have used EFT in their healthcare regime, either as part of their self-care routine or via professional therapeutic interventions. Pregnant women, people under palliative care, and people with cognitive impairments, intellectual disabilities, or mental illnesses were excluded from the study.

Advertisements soliciting participants were published in the e-newsletters and social media sites of professional bodies such as AAMET, EFT Universe, ACEP, and EFT Australian Practitioners (EFTAP). Respondents to advertisements were screened by asking questions about their experience and qualifications (in the case of practitioners) or their health condition (in the case of patients) via telephone or email.

Participants' names were changed to preserve confidentiality.

The present study utilizes two participant voices, namely, EFT practitioners and chronic disease patients. EFT practitioners often recounted their interpretation of their clients' experiences of EFT therapy. It should be noted that, although these accounts offer useful information, they cannot be equated with the clients' direct experiences. However, practitioners' vicarious accounts of their clients' experiences can provide insight into the practitioners' worlds.

## Data Collection

IPA studies often use semi-structured interviews for data collection (Smith & Eatough, 2007). Semi-structured interviews allow researchers to obtain detailed, but targeted information from participants (Liamputtong & Ezzy, 2009; Smith, Flowers, & Larkin, 2009). Semi-structured interviews were consequently adopted as the data collection tool for this study. Interview questions or prompts were formulated such that they enabled participants to share their experiences freely

and descriptively. Practitioners were asked questions about their journeys to becoming practitioners, experiences of administering EFT to chronic disease patients both face-to-face and via telephone and online, general perceptions of EFT as a practice, and experiences of incorporating self-care EFT in clients' treatment regimes. Chronic disease patients were asked questions about their experiences of suffering from illness and use of EFT to support their healthcare, their perceptions of recovery, general opinions on EFT as a technique, experiences of receiving EFT via telephone and online media, and the use of EFT for self-care. Subsequently, the interviews were transcribed verbatim, including nonverbal responses such as laughter, long pauses, hesitation, and other emotional reactions, as these can assist in the interpretative process (Smith et al., 2009).

### *Data Analysis*

The IPA data analysis process outlined in the primary IPA text was adopted for the present study (Smith et al., 2009). Data analysis in IPA constitutes a comprehensive multi-step process:

1. Initial note-taking to capture points of interest
2. Synthesizing preliminary themes by reviewing exploratory notes
3. Grouping and organizing emerging themes to structure data
4. Looking for patterns across cases to create a list of master themes and corresponding sub-themes, and introduce consistency in the wording of super- and sub-themes.

Additionally, reflexive journaling was undertaken to capture the researcher's known and emergent conceptions and responses to the data and assist in the data analysis process.

## **Findings**

### *Experiences of Online EFT Therapy*

Most participants had used EFT either as clients or practitioners through online media such as Skype. Most practitioner participants indicated that they had clients "across the globe" to who they administered therapy online, usually via Skype. Many practitioners had few or no face-to-face clients and had completely web-based practices. A number of interviewed

patients also reported having received therapy via Skype from practitioners located in other cities or countries. Most participants reported no or limited issues with receiving EFT therapy online. For example:

But you know it's pretty much the same as being in the same room with somebody. (Fleur, chronic fatigue syndrome [CFS] patient)

Fleur alludes to the visual functionality of Skype as simulating the effect of being present in same the room with her therapist. Another chronic disease patient, Kayley, who received extensive EFT therapy online from a practitioner located in a different country, elaborated on her use of EFT online:

I don't think there is any difference. I don't think there is any problem with not being face-to-face. I mean when I started working over Skype, I also thought that if I had another option, I would be taking it, I would be going to someone face-to-face. If I knew of someone who was better. But once I started, when you are tapping you go into a different brain state, you are not really, you are not really in the room anyway, you are stuck in your brain, you are somewhere else, in a sort of a trance state. And, umm ... so you can have that trance state in front of a computer, or you can in front of a real person, but either way, it is more about what is going on in your body. (Kayley, CFS patient)

Kayley had initial reservations about receiving therapy online. Referring to her therapist based in another country, she suggests that if she had access to a locally based practitioner of equal or greater skill, she would have preferred face-to-face sessions. One of the WHO health determinants is access to health services. Though no practitioner was available locally, Kayley was able to avail herself of the expertise of a highly skilled practitioner overseas. In fact, Kayley's initial hesitation about receiving online sessions gave way to an acceptance of online therapy. She alludes to the relative insignificance of the physical presence of a practitioner, and instead points to the importance of connecting with one's body and mind (or "brain," as she calls it) for greater therapeutic benefit. Kayley eventually becomes



a proponent of online therapy, as illustrated by the following quote:

There is less distraction. When you are in a room with someone, you can look away, you can look down, you can sort of lose the conversation, you can get confused by body language. You can be, you can be thinking about stuff you will be doing later. When you are in front of a computer, and you don't really look at anything else, and you are there, you are very present when you are in front of a computer. You are not distracted by the room. And I mean you can also have this thing of, you have got a certain like, space, when you are doing it on Skype. There is this sort of like, yeah, I don't know, this different sort of space, than when you are doing it in a room. You are more focused ... And then, also, people have some issues with like dependency and stuff, which I did, a lot, and I fought against it all the time. And then people would become very dependent on a therapist, or very needy for, they have very complicated relationships with their therapists. And, through a computer, it is not easy to fall into that, because you are not there with a, you don't have that availability to you that you're constantly feeling like you need them around, or like you need to see them, or they are always around, but not right there with you. You then, it is harder to fall into that sort of dependency. So that is also another good, a good thing. (Kayley, CFS patient)

Further to the benefit of improved access to a telemental health service, Kayley's quote also points to other "fringe benefits" of receiving therapy online. For example, her use of the vernacular expression "space" is notable and indicates the sense of being in a conducive and suitable therapeutic setting. Additionally, her quote suggests a greater sense of empowerment toward her own health as a client, and reduced risk of dependency on her therapist. EFT practitioner Frank concurred with Kayley on the benefits of therapy administered via videoconferencing:

Sometimes it removes the barriers of being in front of a person ... Because it's just like this computer face, and a voice. And we

can be in a private safe space of our house, where there's no travel. For many people it's actually easier, because there's not someone else's presence in front of them. (Frank, EFT practitioner)

Both Frank's and Kayley's experiences illustrate the reduction of geographical barriers to access to health services when using telemental health applications. Additionally, Frank raises a noteworthy concern that some people may have barriers to seeing a therapist face-to-face and discussing their personal issues in the unfamiliar setting of a therapist's office. Frank suggests that online sessions may offer a reassuring alternative for people in need of help as they obtain support from the comfort of their familiar surroundings. Frank's expression "computer face, and a voice" suggests that online media may offer a useful combination of a helpful therapist along with a safe and familiar home environment for people with reservations about seeking help from therapists. Gulliver, Griffiths, and Christensen (2010) conducted a systematic review of literature investigating perceived barriers to seeking mental health help. They found that perceived stigma and embarrassment about seeking help for mental health emerged as a significant barrier to help-seeking in most of the reviewed studies. Participants in the studies also noted a sense of discomfort in sharing personal problems with strangers. Frank indicates that delivery of therapy through telemental health applications may help reduce discomfort and stigmatization-related barriers to help-seeking.

Participants indicated that while online sessions may be effective, it is also normal for people to have initial misgivings about the use of non-traditional communication technologies such as Skype. However, adequate rapport between the practitioner and the client can help overcome this barrier. For example:

Skype just works best when you've established a relationship. I think when you build that rapport with someone, it doesn't really matter whether you're on Skype or on the telephone or sitting in the room with them. (Daisy, EFT practitioner)

Some practitioner participants, such as Daisy, indicated that an initial face-to-face consultation to help establish a relationship with a client can be a

useful way of helping people overcome their resistance to using Skype in future sessions. However, people's resistance to receiving online therapy also depends on their familiarity and previous experience with the mode of delivery. For example:

I've had clients who I've never met and we've only ever worked on Skype. I think it's, it is also to do with how comfortable the person is with working on Skype ... Clients who seem to be really really able to get the most out of Skype are people who use it for their work, say, it's a very familiar medium. Whereas, you know, I had one client who was very anxious, really in the middle of a trauma and kind of uncomfortable about using Skype [laughs] and we did two sessions and although we made some headway in the session, it just, it just wasn't as profound as if she'd been, sat with me in the room. (Daisy, EFT practitioner)

Daisy's quote raises an important issue regarding the significance of familiarity with technology. Familiarity with technology may be considered as one of the health determinants of the WHO criteria of education, income and social status, and physical environment. Access to and familiarity with technological applications is likely to be more prevalent in people in higher socioeconomic classes and those residing in urban areas with advanced telecommunications infrastructure. As such, while online therapy may be a useful means of breaking geographical barriers to access, it poses challenges for clients with inadequate education in the use of technology, clients without the financial resources to access computers and Internet connections, and those residing in remote or regional areas lacking the infrastructure required to run videoconferencing technology. Telephone delivery of EFT may be more accessible to people residing in remote regions, those without requisite financial resources, and those lacking education in the operation of advanced videoconferencing software and hardware. Telephone delivery of EFT is discussed further in the following section.

Despite the challenges associated with the use of online therapy, it can also offer many unique ways of augmenting the therapeutic experience of those with access to it. For example:

I mean you can send people tapping scripts, you can, you know, show them

bits of video, yeah, there's just so much stuff you can do within Skype. We can just have everything, you can send someone an e-book. It's all just there, kind of immediately, isn't it? (Daisy, EFT practitioner)

Daisy is alluding to the various functionalities that videoconferencing platforms offer, such as the ability to share documents or send links to helpful online videos in real-time during therapy sessions. Practitioners may be able to immediately share useful resources to further assist their clients. However, online delivery of therapy is not without its challenges, the most common being technical malfunctions. For example:

With Skype, you might be more likely to get technical issues, you might lose contact for a minute, which is not so great in a session [smiles]. (Iris, EFT practitioner)

If Skype is having a bad day and there's dropouts or things like that, it can be extremely [emphasizes "extremely"] disruptive, but fortunately that happens quite rarely. (Rachel, EFT practitioner)

Technical issues in the middle of a therapy session can be disruptive when the practitioner and client are discussing emotionally charged issues. Rachel indicates that, in her experience, technical issues with videoconferencing services are rare. However, Rachel lives in a major metropolitan city with adequate telecommunications infrastructure. Technical issues pose greater connectivity challenges in rural and remote areas.

### *Experiences of Telephone Delivery of EFT*

As previously mentioned, online delivery of EFT interventions may not be possible for people living in areas with limited telecommunications connectivity, lack of the resources required to obtain the required equipment, or a paucity of education in the use of technology. In cases where online delivery of EFT is difficult or not possible, telephone delivery may offer a more viable and economical alternative. Participants talked about their experiences of EFT interventions delivered via telephone. However, unlike online sessions, visual cues are not available in telephone sessions. As such, practitioners have to rely completely on



the voice of the client to facilitate the session and guide the therapeutic process. For example:

I think it's a skill to be able to listen well enough and to be able to use the phone. And so some people are uncomfortable without the visual cues, that that's an issue. But I don't find that an issue ... I mean you can pick up a lot in the voice ... And I also think that energetically I pick up on stuff. Just being with someone, energetically I can feel you know, partly through the voice, but also I think energetically, you are being attuned and being connected. (Iris, EFT practitioner)

I found you get very intuitive to pick up the sounds and tones, the voice, the pauses and all that and there's lots of clues you get. But it's different than the visual clues. But I found it really easy. I still do sessions by phone, with some people who are not techie, so we just do phone sessions, and it works beautifully. (Donna, EFT practitioner)

EFT practitioners Iris and Donna acknowledge that telephone delivery of EFT comes with its limitations, in that some people may find it hard to engage with the therapeutic process without the presence of visual cues. However, Donna and Iris indicate that there are alternative means of connecting with clients during sessions delivered via telephone. In particular, they emphasize the importance of being observant of the client's voice, words, and tones and sounds, as well as nonverbal responses such as pauses. Additionally, they also allude to an intuitive connection with the client, whereby, through exercising genuine attentiveness and empathy, they are better able to understand the client's state of mind and appropriately guide the therapeutic process.

In the previous section, EFT practitioner Daisy's experience with a client who was apprehensive about using Skype was discussed. Daisy thought that her client's reservations about online therapy had resulted in compromising the therapeutic benefits of the work. This issue is also elucidated in Donna's quote above. She uses telephone sessions for clients who are not "techie." Telephone delivery, by adequately skilled practitioners, may be effective for clients without the education or resources to access advanced telecommunications infrastructure.

Practitioners noted the value of telephone EFT for clients residing in rural or remote areas. For example:

I feel it not only is incredibly effective, but it potentially saves costs, it provides a lot faster improved treatment than, because I know some regional centers you know, they just, don't necessarily have the most up-to-date technology and doctors and training ... Also may not have the most like, staff hours available ... But one of the other key things which is, maybe overlooked which I recommend ... worth mentioning, it's really important that, as you probably know one of the key aspects of trauma, is actually feeling isolated. So having someone you can call that's actually available even if you're off in the middle of a farm in the middle of nowhere ... and help reduce the isolation. Rather than you having to drive there on your own like 5 hours, or 2 hours of waiting and all this kind of stuff, that alone is incredibly powerful for people. (Frank, EFT practitioner)

Frank's quote indicates a number of benefits, including cost-effectiveness, time saving, and immediate service. Frank's comment on the impact of feeling isolated can be viewed in the context of the WHO social support health determinant. Telephone EFT may offer people a service that is readily available and helps them feel supported.

Despite their benefits, telephone sessions have limitations, most notably the lack of visual cues. As such, practitioners stressed the importance of ensuring that their clients are familiar with the EFT protocol and the locations of the various tapping points. This is important to ensure that clients can be effectively guided through the tapping process verbally. Practitioners indicated that clients may be taught the EFT process over the phone, or they can be sent instructions beforehand to help familiarize them with the technique. For example:

When you are talking to them, making sure that you are being really clear, about where the points are, if they are new to EFT. (Iris, EFT practitioner)

Now in terms of teaching EFT over the phone, most people grasp the process quite quickly. Just as I describe the location of points, I do also send them a video,

demonstrating the location of the points as well as a chart, a visual chart of the points. (Rachel, EFT practitioner)

Rachel often emails resources to clients prior to her sessions with them. However, where email access is not available, Iris and Rachel note that by clearly communicating the tapping process, clients can be taught the technique promptly over the telephone.

Though the absence of visual cues may be a limitation, some participants also indicated that it can, in fact, be a strength and minimize distractions, while assisting clients to better engage with their emotional states. For example:

Many of my clients actually prefer to work over the phone because they have their eyes closed a lot during the process and so they can kind of, you know, go inside a lot better if they are in the comfort of their own home, in a room that they are familiar with. (Rachel, EFT practitioner)

Rachel's use of the expression "go inside a lot better" is noteworthy in that it alludes to the importance of heightened self-awareness during an EFT session. She indicates that, in her experience, being on the telephone, without having a practitioner looking at them, helps clients remain more focused on their emotions, while being in a comforting home environment.

### *Online Communities of Support*

One of the WHO determinants of health is social support networks. WHO states that support from family, friends, and the broader community is linked with good health (WHO, 2016). The study's participants indicated that when a person is chronically ill, he or she may suffer from feelings of isolation due to not being able to engage in experiences that were previously "normal" or relate to old friends.

Abigail is an EFT practitioner who specializes in working with people with chronic diseases. Abigail herself had suffered from CFS earlier in her life:

I think to have somebody to turn to and find that they can [emphasizes "can"] relate. Even if my background is different to theirs, and the illness is different; because obviously I work with people with all sorts of illnesses; at least I know what it means

to be isolated, at home, without work, friends dropping like flies because they can't relate to it, and feeling as though nothing will ever change. So I think that's a big part of why I got the number of clients I did. (Abigail, EFT practitioner)

Here, Abigail aptly describes the plight of people with chronic diseases. Her quote points to emotional challenges faced by chronic disease patients such as feelings of isolation and hopelessness. Her use of the expression "friends dropping like flies" is particularly powerful and points to the rapid change in social networks, and reduced relatability and connectedness with previous friends in light of the patient's new health needs and circumstances. Abigail's apparent popularity as a practitioner, attributed by her to her relatability with clients, demonstrates the importance of support networks for chronic disease patients.

A qualitative study was undertaken to understand the experiences of rural women suffering from fibromyalgia (Cudney, Butler, Weinert, & Sullivan, 2002). Patients reported being isolated from support, information, and services. It was not logistically possible for them to get access to fibromyalgia support groups, or have interactions with other people suffering from the same health condition (Cudney et al., 2002). In addition, having a condition that is not very well understood by the medical community caused them to feel lonely and emotionally isolated, which made it harder to cope with their disease (Cudney et al., 2002).

Several participants of the present study emphasized the need for having support networks when one is suffering from a chronic health condition. In fact, some practitioner participants stated that they ran online support groups for people with chronic diseases:

My colleague and I created this online support system [Women's Wellness Circle] for women with chronic health problems ... So we have had women with autoimmune conditions, cancer, fertility issues, all kinds of different health issues, a lot of severe digestive problems, and so when they first sign up, to find out what we do, they get a free mini health course, a couple of videos on EFT, and other things ... And we have got a Facebook circle where everyone connects with each other and reaches out for support, and then we run these online

courses every now and again ... One of the reasons of what we do actually, that's to build connections. Like we have had women say, "This is a complete lifeline for me. I am stuck in my flat, on my own, all the time. I don't know where I would be without this group." And like, you know, we have had women really say, "Thank you, you are saving my life," sort of thing [laughs] ... And people have been like, "This is amazing what you are offering." We always do some EFT as part of it. And the other thing, the idea, of it is that when women get together in a conscious supportive way that actually, in itself, is very healing. (Iris, EFT practitioner)

The quote by Iris provides a powerful example of how EFT can be offered to groups of people online in various forms, such as through videos, websites, and online courses. Online courses, coupled with a virtual community, provide women with chronic health conditions a safe space to find connections and share their experiences, while empowering each other and learning helpful techniques for managing their conditions.

While Iris runs a well-structured online support program, other practitioners offer smaller-scale group therapy. Practitioner Donna administers an "online conference room," a web-based group conferencing platform in which she offers group EFT sessions.

### *EFT for Self-care*

One of the determinants of health in the WHO formulation is genetics, which includes people's personal behaviors, coping mechanisms, lifestyle habits, and the general ability to deal with life's stressors and challenges (WHO, 2016). EFT is a technique that can be self-administered by users. Participants discussed their use of EFT for coping, symptom management, and dealing with daily life's "ordinary" stressors, or what some of them referred to as "maintenance tapping." For example:

[I say to my clients] "This is now time for you to be very self-aware, and observing everything and anything that is coming up for you. How are you responding to life? Period. So your husband looks at you in a certain way. He is totally distracted,

he is not meaningful. But, it makes you cross, or it upsets you. Tap on that. Or [you] learn that your son is stressed about going to school tomorrow. Tap on that. Whatever it is, get tapping, and use these as opportunities to tap." ... Most usually I hear, "But I don't know what to say," and, I say, "Imagine that you are calling a friend on the phone. You wouldn't think, 'What shall I say?' You would just vent." So, the homework that I usually set is "tap and vent." (Abigail, EFT practitioner)

As apparent from Abigail's quote, she encourages her clients to apply EFT to any emotionally unsettling events, no matter how big or small her clients may perceive those events to be. The quote, particularly, the expression "tap and vent," also illustrates the flexibility that EFT offers users. It indicates that users do not need extensive training to be able to use this technique. Instead, merely adopting an informal conversational approach during tapping can be a useful and easy means of managing emotions on a daily basis. Abigail further elaborates on the use of EFT for daily stressors in light of those stressors' impacts on long-term health:

If somebody is driving down the freeway and they are cut off by a driver, they can immediately tap on that. If their stomach hurts, they can tap on it, or they feel a headache coming up. So I believe that if everybody has this tool as a self-care method, then that would avoid the chronic illness in the first place. [Laughs] Because, anything that came up for them, frustration, fear, sadness, guilt, I mean they could just be tapping on it straight off, and then we don't need [emphasizes "need"] this snowball effect to start. I mean ... I use a rain barrel analogy. So it's important that as the rain pours in, we can contain the level of the water. And, it is clear to me, that most of us can't. So there is a tipping point, and the rain barrel overflows. But, if we are using it as a self-care tool or method, then that tipping point doesn't need to happen. (Abigail, EFT practitioner)

Abigail refers to an emotional threshold, which she calls a "tipping point," up to which a person can tolerate emotional distress, after which the

stress will begin to impact the person's well-being. Abigail's quote points to EFT as a preventative self-care tool for maintenance and preservation of good health. McEwan and Stellar (1993) proposed a concept called "allostatic load," which represents the wear and tear a person's physical body experiences as a result of chronic stress subjected over an extended period of time. They indicated that chronic stress can predispose individuals to development of disease. Abigail's explanation of the "tipping point" appears congruent with the conceptual formulation of allostatic load.

The WHO recognizes the importance of self-care in the management of a person's health (WHO, 2016). Participants in the present study noted that with the ease of self-application of EFT comes a sense of empowerment in users:

In traditional therapy a lot of patients depend on the therapists ... And if they get in crisis they go "Oh my god, I have to call my therapist!" But EFT is a technique you can use anytime, anywhere; so not only does it deactivate your stress response, but it enables you to become the person that helps yourself. (Cassandra, CFS, fibromyalgia patient)

Cassandra's quote highlights the ease of self-application of EFT. Her expression "become the person that helps yourself" is particularly noteworthy and alludes to the sense of empowerment that patients feel, as well as the reduction of their dependency on therapists. Participants also alluded to the application of EFT for people who do not feel comfortable seeking help from therapists. For example, Candace applied EFT to manage fibromyalgia and migraine headaches:

I am the type of person who is like, you know, self-reliant, want to be on my own ... like I want to be self-reliant, and ... I had all the skills. And I just did it by myself. (Candace, fibromyalgia and migraine patient)

Candace's claim that she "had all the skills" needed to self-administer EFT to manage her health is noteworthy given that she had only undertaken some basic EFT training. EFT practitioner Donna further elaborated on the role of EFT for self-care:

I always recommend that people do their own tapping. Because I am not there 3 in the

morning, if they are not sleeping, but they can use a tool that will help them relax ... they have a tool that's within their hands, their fingertips, it's always there, with them and I found [find, *sic*] that really really useful. (Donna, EFT practitioner)

Donna notes the practical benefits of EFT in situations in which seeking help from professionals may not be logistically possible. Her quote illustrates the ability of EFT to be immediately applied under distressing circumstances.

## Discussion

Participants in the present study noted that the delivery of EFT via telemental health applications such as telephone, teleconferencing, online groups, virtual courses, and Skype offers a useful alternative for people without access to locally available practitioners, in particular, people residing in rural or remote areas. The general health of rural people across the world is worse than that of urban people (Strasser, 2003). A number of factors contribute to this, particularly limited access to health services and information, and a shortage of qualified health professionals in rural areas (Strasser, 2003). Even in countries where a large part of the population is rural, resources and services are concentrated in city centers (Strasser, 2003). Rural people often have to wait a long time to get appointments with health practitioners. Counseling services are also limited in rural areas. These parameters impact rural people's ability to gain access to health services, which, in turn, can negatively impact people's health. Participants' accounts suggest that online and telephone EFT may provide an alternative for effective and speedy therapy to patients with geographical barriers to psychological health services.

A study (Edirippulige, Levandovskaya, & Prishutova, 2013) investigated the use of Skype for provision of psychotherapy (e.g., psychoanalysis, psychodrama, Gestalt therapy, cognitive behavioral therapy, existential therapy). A majority of the study's participants, both practitioners and clients, reported a high degree of satisfaction. Although the participants in the present study noted several benefits of Skype, such as the presence of visual cues, they raised concerns regarding familiarity with technology,



technical issues during Skype calls, and access for people residing in areas with limited Internet connectivity.

Telephone EFT may offer a suitable alternative for people averse to or unable to use videoconferencing technology due to lack of education or resources, or the perceived social stigma of seeking the services of a mental health professional. A study investigating telephone delivery of EFT to veterans with PTSD symptoms found that it was effective in two thirds of cases (Hartung & Stein, 2012).

Another important emergent theme in the present study was the value of online social support networks, one of the WHO health determinants. A study found that an online support group was beneficial for reducing depression, cancer-related trauma, and perceived stress in 72 women with breast cancer (Winzelberg et al., 2003). Participants were able to reduce social isolation, offer each other coping advice, and freely discuss their problems and concerns with other women suffering from similar issues. One of the present study's participants also runs an online support group called Women's Wellness Circle and reports similar benefits such as social support, dissemination of coping techniques, and a peer group forum in which participants can freely express themselves.

The final theme was the importance of self-care. Participants discussed the self-administration of EFT producing a sense of self-reliance and empowerment with regard to their own emotions and well-being. Literature indicates the importance of maintaining "emotional balance" to enable psychological adjustment to a chronic disease (De Ridder, Geenen, Kuijter, & Van Middendorp, 2008). Patients who are able to maintain positive moods are more likely to be willing to make lifestyle changes. Additionally, self-care and self-management practices are also linked with improved well-being (De Ridder et al., 2008). Participants of the present study indicated the use of EFT for managing daily life "ordinary stressors," which, in turn, may result in elevated mood levels and well-being.

Remote EFT therapy and self-administration of EFT therefore corroborate the WHO determinants of health. Participants' accounts illustrate EFT's value in reducing barriers to access to health services, and its role in facilitating self-care in chronic disease patients.

## References

- Boath, E., Stewart, A., & Carryer, A. (2012). *A narrative systematic review of the effectiveness of Emotional Freedom Techniques (EFT)* [Monograph]. Centre for Practice and Service Improvement, Staffordshire University. Retrieved from [https://www.staffs.ac.uk/assets/A\\_narrative\\_systematic%20Review\\_of\\_the\\_effectiveness\\_of\\_Emotional\\_Freedoms\\_Technique\\_\(EFT\)\\_tcm44-45500.pdf](https://www.staffs.ac.uk/assets/A_narrative_systematic%20Review_of_the_effectiveness_of_Emotional_Freedoms_Technique_(EFT)_tcm44-45500.pdf)
- Brattberg, G. (2008). Self-administered EFT (Emotional Freedom Techniques) in individuals with fibromyalgia: A randomized trial. *Integrative Medicine: A Clinician's Journal*, 7(4), 30–35.
- Church, D. (2013a). Clinical EFT as an evidence-based practice for the treatment of psychological and physiological conditions. *Psychology*, 4(8), 645–654.
- Church, D. (2013b). *The EFT manual* (3rd ed.). Santa Rosa, CA: Energy Psychology Press.
- Church, D., & Feinstein, D. (2013). Energy psychology in the treatment of PTSD: Psychobiology and clinical principles. In Van Leeuwen T., & Brouwer M. (Eds.), *Psychology of trauma* (pp. 211–224). Hauppauge, NY: Nova Science Publishers.
- Clond, M. (2016). Emotional Freedom Techniques for anxiety: A systematic review with meta-analysis. *Journal of Nervous and Mental Disease*, 204, 388–395.
- Coulter, A. (2013). Understanding the experience of illness and treatment. In Ziehlend S., Coulter A., Calabrese J., & Locock L. (Eds.), *Understanding and using health experiences: Improving patient care (1849–1919)*. Oxford, UK: Oxford Scholarship Online.
- Craig, G., & Fowlie, A. (1995). *Emotional Freedom Techniques: The manual*. Sea Ranch, CA: Gary Craig.
- Cudney, S., Butler, M., Weinert, C., & Sullivan, T. (2002). Ten rural women living with fibromyalgia tell it like it is. *Holistic Nursing Practice*, 16(3), 35–45.
- De Ridder, D., Geenen, R., Kuijter, R., & Van Middendorp, H. (2008). Psychological adjustment to chronic disease. *Lancet*, 372(9634), 246–255.
- Edirippulige, S., Levandovskaya, M., & Prishutova, A. (2013). A qualitative study of the use of Skype for psychotherapy consultations in the Ukraine. *Journal of Telemedicine and Telecare*, 19(7), 376–378.
- Feinstein, D. (2010). Rapid treatment of PTSD: Why psychological exposure with acupoint tapping may be effective. *Psychotherapy: Theory, Research, Practice, Training*, 47(3), 385–402.
- Feinstein, D., & Church, D. (2010). Modulating gene expression through psychotherapy: The contribution of non-invasive somatic interventions. *Review of General Psychology*, 14(4), 283–295.
- Gulliver, A., Griffiths, K., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*, 10(113), 1–9.
- Hailey, D., Roine, R., & Ohinmaa, A. (2008). The effectiveness of telemental health applications: A review. *Canadian Journal of Psychiatry*, 53(11), 769–778.
- Harper, M. (2012). Taming the amygdala: An EEG analysis of exposure therapy for the traumatised. *Traumatology*, 18(2), 61–74.
- Hartung, J., & Stein, P. (2012). Telephone delivery of EFT (emotional freedom techniques) remediates PTSD symptoms

- in veterans. *Energy Psychology: Theory, Research, and Treatment*, 4(1), 33–40.
- Liamputtong, P., & Ezzy, D. (2009). *Qualitative research methods*. South Melbourne, Australia: Oxford University Press.
- McEwan, B., & Stellar, E. (1993). Stress and the individual: Mechanisms leading to disease. *Archives of Internal Medicine*, 153(18), 2093–2101.
- Nelms, J., & Castel, D. (2016). A systematic review and meta-analysis of randomized and non-randomized trials of Emotional Freedom Techniques (EFT) for the treatment of depression. *Explore: The Journal of Science and Healing* (in press).
- Sebastian, B., & Nelms, J. (2016). Emotional Freedom Techniques (EFT) for posttraumatic stress disorder: A systematic review and meta-analysis. *Explore: The Journal of Science and Healing* (in press).
- Smith, J. (2010). Interpretative phenomenological analysis: A reply to Amedeo Giorgi. *Existential Analysis*, 21(2), 186–192.
- Smith, J., & Eatough, V. (2007). Interpretative phenomenological analysis. In Lyons E., & Coyle A. (Eds.), *Analysing qualitative data in psychology* (pp. 35–51). London, UK: SAGE.
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London, UK: SAGE.
- Stapleton, P. B., Sheldon, T., & Porter, B. (2012). Clinical benefits of Emotional Freedom Techniques on food cravings at 12-months follow-up: A randomized controlled trial. *Energy Psychology: Theory, Research, and Treatment*, 4(1), 1–12.
- Strasser, R. (2003). Rural health around the world: Challenges and solutions. *Family Practice*, 20(4), 457–463.
- Winzelberg, A., Classen, C., Alpers, G. W., Roberts, H., Koopman, C., Adams, R. E., ... Taylor, C. B. (2003). Evaluation of an internet support group for women with primary breast cancer. *Cancer*, 97(5), 1164–1173.
- World Health Organization (WHO). (2016). *The determinants of health*. Retrieved from [http://guides.lib.monash.edu/ld.php?content\\_id=12586146](http://guides.lib.monash.edu/ld.php?content_id=12586146)

## Chapter Summary

This was the final results chapter that presented emergent findings in relation to the usefulness of telephone/internet delivery and self-administration of EFT in the context of the determinants of health. Underpinned by the WHO determinants of health, this chapter placed the practice of EFT in the context of patients' social environment. The findings presented in this chapter were informed by both practitioner and patient participants' interviews. Four themes were presented in this chapter, namely: 'practitioner and client experiences of online EFT therapy', 'experiences of telephone EFT therapy', 'experiences of online support groups', and 'the use of EFT for self-care'. Participant accounts illustrate EFT's value in alleviating barriers to access of health services and also facilitating self-care in chronic disease patients. Online and telephone delivery of EFT may provide a useful alternative for residents of remote and rural areas without access to mental health services. EFT may also be used to provide online social support to chronic disease patients via videoconferencing platforms. The next chapter will now present a synthesis of the emergent findings, provide recommendations for practice and future research, and conclude this thesis.

# Chapter 8: Discussion

---

This thesis explores EFT experiences of eight chronic disease patients, and eight EFT practitioners, for supporting chronic disease healthcare using a constructivist epistemological perspective. The previous four chapters presented the findings emergent from the analyses of patient and practitioner participants' qualitative interviews, with each chapter addressing one research objective. This chapter presents a synthesis of the emergent findings in light of the literature explored in Chapter 2. This chapter, which is the final chapter of this thesis, also discusses the study's limitations, provides recommendations for future research and practice, and concludes the thesis.

Underpinned by a biopsychosocial view of health, this study aimed to explore users' experiences of EFT for supporting chronic disease healthcare from both psychological and social perspectives. The research objectives that I set out to explore were:

- EFT practitioners' perceptions and experiences of using EFT to support chronic disease healthcare;
- chronic disease patients' personal symbolic meanings of their illnesses as emergent from their experience of EFT therapy;
- chronic disease patients' personal notions of recovery; and
- practitioners' and patients' experiences of telephone/internet delivery and self-administration of EFT in the context of the WHO determinants of health.

As previously noted, each of the above research objectives were addressed in a separate results chapter. The purpose of the current chapter is to explore the study's findings within the context



of the findings' application for chronic disease healthcare practice and research. The literature discussed in Chapter 2 highlighted the need for taking healthcare beyond disease-specific approaches, to approaches which aim to integrate patients' individual needs (e.g. Stewart, 2001). My study's findings also allude to the complexity of chronic disease healthcare and the need for healthcare approaches that are focused around patients' individual life circumstances and needs.

Some models of comprehensive chronic disease healthcare which aim to put the patient at the centre of healthcare have been discussed in extant literature. However, these appear to be focused around the provision of medical and clinical support services. For example, the Commonwealth Department of Health in Australia commissioned a Primary Health Care Advisory Group to develop a report on "Better Outcomes for People with Chronic and Complex Health Conditions" (DoH, 2015). DoH (2015, p. 14) identified some key aspects of "effective and appropriate care for people with chronic and complex conditions". The aspects of care identified by DoH (2015) include:

- assessment of patients' health related risks and requirements;
- development of care plans based on patients' needs and preferences;
- engagement of patients and their family members in care management;
- supporting patient liaison with support/allied health services;
- facilitating communication among the patient's various medical and support care providers; and
- monitoring progress and follow-up.

While the above aspects of care include a social dimension, e.g. including the patient's family in healthcare management, and endeavouring to increase patient participation in their own healthcare, the focus appears to be on the provision of adequate medical and allied support and associated

logistics. Greater patient participation in their healthcare has been linked with improved quality of life, and physical and social functioning (Hack, Degner, Watson & Sinha, 2005). Holman and Lorig (2000), who also promoted the role of a patient as an active partner in chronic disease healthcare, provided an overview of several approaches for improving patient participation in their healthcare. However, most of these approaches also appear focused on the provision of medical and support services, with a component of self-management, rather than on the patients' individual life-worlds.

For example, Holman and Lorig (2000) described group visits involving meetings of groups of patients with their doctors to discuss concerns related to their diseases as an approach to increase patient participation in their own healthcare. Another recommended approach is remote medical management which involves telephone or electronic communication-based management consultations between the patients and service providers (Holman & Lorig, 2000). The third approach described by Holman and Lorig (2000) involves self-management education around medication use, learning to interpret symptoms and changes in disease, and utilising community and medical resources. This approach also contains a psychosocial aspect that entails adaptation of patients to social and workplace-related disruptions, coping with emotional responses to the illness, and general behaviour change.

The examples of models provided above, while pointing to the patient as a participant in their own healthcare, do not go into great depth about the placement of the illness within a patient's 'life-world'. There is expansive literature on patients' and health practitioners' experiences within the context of generic chronic disease healthcare (e.g. Schoen, Osborn, How, Doty & Peugh, 2008), as well as specific chronic conditions (e.g. Seamark, Blake, Seamark & Halpin, 2004; Cudney et al., 2002; Bramley & Eatough, 2007; Haugli, Strand & Finset, 2004). However, this literature appears to focus on experiences of illness, healthcare services, and self-management support, rather than the patient's unique life-worlds, as my study does.

Even models which include psychosocial aspects of health appear to focus on the practical or logistical side of provision of support services, e.g. receiving welfare support from government; receiving the required support from allied services; and including family members in care management plans. However, there is limited literature that explores the *type of support a patient may need in the context of his/her life-world*. For example, existing models may focus on facilitating patients' transition to altered work arrangements, but not the emotional responses and impacts of those responses on the patient's self-identity and quality of life. In other words, while the practicalities of patients' illness and healthcare experiences have been widely investigated, the exploration of the illness and healthcare experience in the context of a patient's life-world is limited. The findings of the current study add another layer to the existing chronic disease healthcare literature by exploring how an illness may impact a patient's *life-world*, and what areas of the patients' lived experience may need support to improve patients' quality of life. In order to fill the gap in the existing healthcare models, and in light of the literature review presented in Chapter 2, as well as my study's findings, I propose another model of chronic disease healthcare, which is contextualised within the patient's life-world.

### **Proposed Model: Using EFT to support chronic disease healthcare for the patient as a whole-person**

The good physician treats the disease; the great physician treats the  
patient who has the disease.

- William Osler (Father of Modern Medicine)

The research aim that I set out to explore in this thesis was EFT practitioners' and chronic disease patients' experiences of using EFT to support chronic disease healthcare. The research objective

was underpinned by a ‘personhood’ approach to healthcare, which points to the need for healthcare to be centred on the cumulative knowledge of the patient as a whole-person, and patients’ individual needs. My exploration in this study therefore led me to consider what the patient - a whole-person who has the disease - might need. Through a synthesis of my study’s findings, I thus propose an alternate chronic disease healthcare model, ‘Using EFT to support chronic disease healthcare for patient as a whole-person’. The proposed model may be used by EFT practitioners as well as patients who may wish to play a more active role in their own healthcare regimes.

Emergent from a constructivist perspective, this model is intended to serve as an indicative guide about the various facets of a patient’s life-world that may need addressing. This model endeavours to provide prompts for triggering discussions and further exploration between a patient and their EFT practitioner. This model is also underpinned by a biopsychosocial view of health, which means that it views emotional and physical systems and processes as being inter-linked and inter-dependent. A pictorial representation of this model is provided in Figure 8.1. The patient is viewed as a whole-person situated within a social context or environment. The patient as a whole-person requires support to address both emotional and physical aspects of their life-world. The emotional and physical aspects are also inter-related and interact with each other.

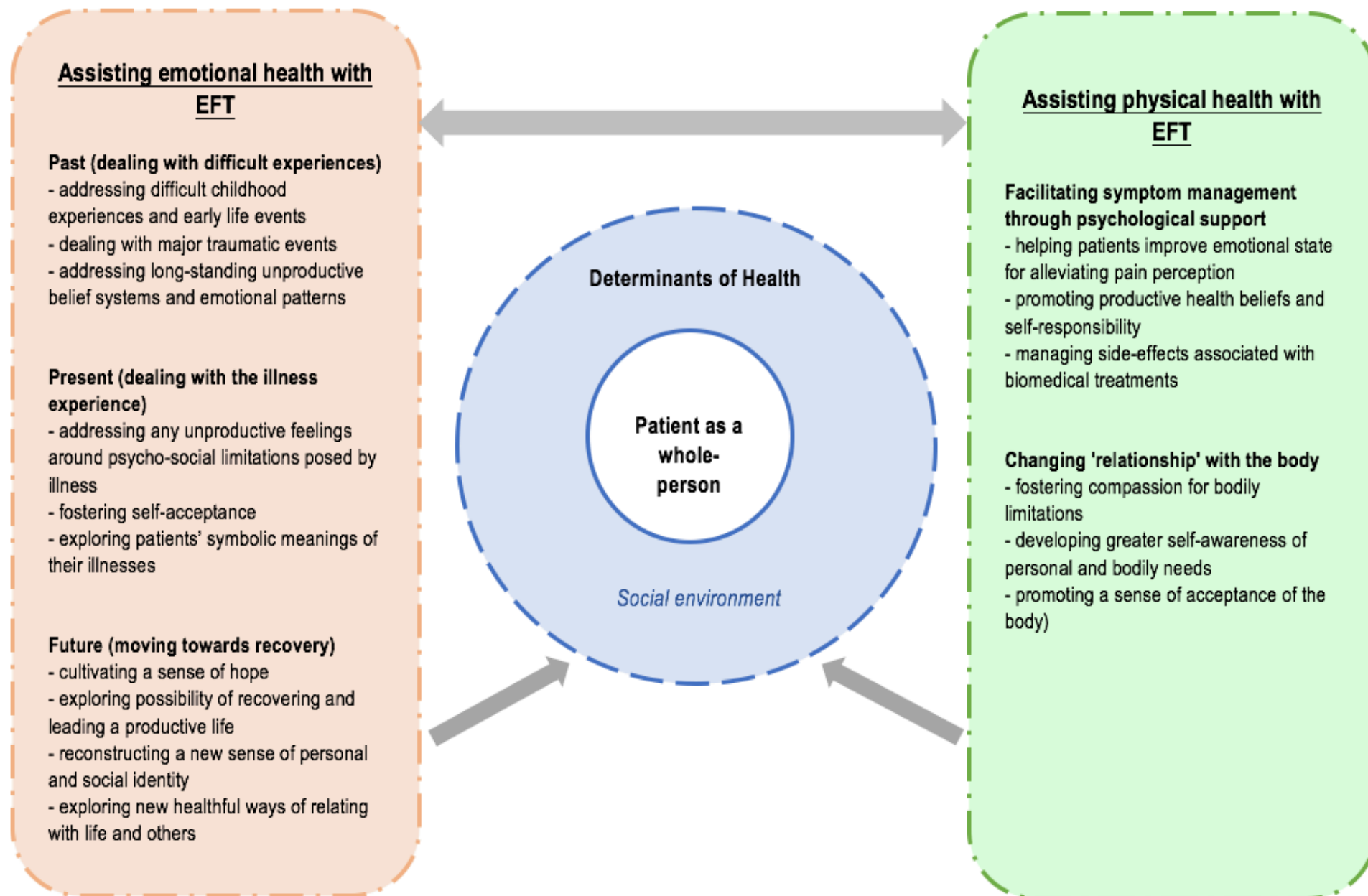


Figure 8.1: Using EFT to support chronic disease healthcare for patient as a whole-person

The following sections will now expound the aforementioned proposed model, in light of the literature discussed in Chapter 2, and my study's emergent findings. This model was designed to be a synthesis of my study's findings, which means that it needed to be sufficiently comprehensive. At the same time, this model was conceptualised with the view to serve an 'applied' purpose in medical/health practice; to act as a 'health-care for the patient as a whole-person' tool-guide for patients and EFT practitioners alike.

Ensuring the transferability of this model into healthcare practice called for a simple but not 'simplistic' exposition. In order to balance the desired level of comprehensiveness with simplicity I have adopted a sequential approach to explicating this model. I will now delve progressively into each of the 'emotional', 'physical', and 'social' aspects of this model. Within each of these broader components, there are two to three main motifs, each of which represents an amalgamation of the findings emergent from my study. At the end of each sub-element, I provide recommendations for EFT practitioners. These recommendations can be thought of as my study's implications for health practice. While these recommendations are pitched towards EFT practitioners, given a person-centred healthcare basis of this study, whereby the patient is seen to have agency in their own healthcare, these recommendations also hold much value for the patient who may be on their own exploratory wellness journey.

### **Emotional health of the patient as a 'whole-person'**

The current section exposits the 'emotional health' aspect of the patient as a whole-person, through a temporal view of the patient's life-world. I propose that a patient may need to address emotional issues associated with their past, present and future, as follows:

- **Past:** Addressing past difficult experiences;
- **Present:** Dealing with the current illness experience; and

- **Future:** Moving towards recovery.

### *Past: Addressing past difficult experiences*

Participants' accounts in this study alluded to the importance of addressing early life issues, past-traumas, and other long-standing belief systems and emotional patterns. In Chapter 2 (Literature Review), I presented Cunningham and Watson's (2004) hypothesis that psychological predisposition to disease can develop during childhood, if a person is exposed to chronic stress (e.g. excessive fear, anger or depression) while growing up. This chronic stress-induced wear and tear, referred to as 'allostatic load', coupled with stress hormones is considered to contribute to physiological changes in the body which may render the body susceptible to disease (McEwen & Stellar, 1993).

Cunningham and Watson (2004) suggested that a reduction in allostatic load through psychotherapeutic support can assist patients improve their quality of life and overall physical health. In this study, both patient and practitioner participants described their use of EFT for addressing early life issues, and past experiences. Participants' accounts illustrated that difficult past experiences may need to be addressed regardless of their apparent 'importance'. For example, CFS patient Fleur, noted that, through EFT, she addressed her feelings around a childhood event where, "I thought my dad was being really unfair about a bike that he was going to buy me [laughs]". Fleur admitted to addressing these "little random things I had obviously become attached to and created a story about". Fleur further suggested that "over the years, the story had built up and become quite a big thing". Additionally, Fleur also recounted her use of EFT to address emotional issues associated with what may be considered a major traumatic event, involving abuse that she had suffered during childhood. Participants' accounts illustrate that there may be therapeutic value in addressing past difficult experiences ranging from seemingly minor events, such as not getting the bicycle Fleur wanted as a child, to what may be perceived as major

traumatic events such as an incident of abuse. Schnurr and Green (2004) present evidence that poor physical health should be considered concurrently with psychosocial dysfunctions, and as a product of traumatic experiences.

Participants' accounts also illustrate that past traumatic events, or other difficult life experiences can co-relate to the emergence of unhealthy behavioural or emotional response patterns. For example, EFT practitioner Rachel, described how tackling behavioural or emotional response patterns (e.g. addictive responses to food, feelings of being unworthy or unlovable), can become segues to addressing difficult childhood experiences in her clients, such as having controlling parents, not feeling loved as a child, feeling that a sibling was preferred over them, facing childhood abuse and so on. Wonderlich, Crosby, Mitchell et al. (2001) suggested that childhood sexual abuse may have strong links with the presence of binge-eating, and other self-destructive impulsive behaviour patterns during adulthood. Davis, Luecken and Zautra (2005) also report meta-analytic evidence to suggest that individuals who report having faced abusive or neglectful experiences during childhood may be at greater risk of developing chronic pain later in adulthood, compared to those who do not report these difficult childhood experiences.

### **Summary: Recommendations for practice**

**EFT practitioners are recommended to help patients:**

- address feelings around difficult childhood and early life events;
- deal with major traumatic events; and
- address long-standing unproductive belief systems and emotional patterns.

### ***Present: Dealing with the illness experience***

Participants' accounts of this study demonstrated that an illness experience may bring about negative feelings, thoughts, and beliefs about oneself, life in general, relationships and so on. An illness may also pose psychosocial limitations on a patient, such as restricting patients' ability to



continue paid employment and engage in social activities. Walker (2010), for example, noted that such limitations posed by an illness experience can leave patients questioning their social identities, and experiencing reduction in their self-esteem, and subsequent feelings of loss. Participants of this study described the use of EFT for ‘coming to terms with’ these limitations, gaining a sense of ‘acceptance’ around the illness experience, and dealing with general feelings around the illness (e.g. anger, fear, frustration).

Dealing with the illness experience can be different for different people. For example, for some, dealing with an illness may involve addressing feelings of guilt, shame, and so on, at not being able to fulfil their social and economic roles. For instance, EFT practitioner Taylor, described the experience of Tapping with a client who was feeling like she was not meeting her familial and job-related obligations due to her illness, using statements such as “even though, I am struggling, I am okay”; and “even though I am failing as a mother, failing as an employee, I am alright”. Participants’ accounts suggest that there may be therapeutic value in addressing patients’ meanings of what it means for them to be ill, including perceptions of self, negative feelings, self-blame and so on.

For some people, dealing with an illness may involve coming to terms with the shock or confusion around developing an illness at a certain time in their lives. For example, EFT practitioner Samantha, recounted her experience of helping a client in her twenties who had developed Rheumatoid Arthritis at a young age. Samantha assisted her patient address the shock, meanings, and beliefs around her experience of developing Rheumatoid Arthritis at a young age, through Tapping statements, such as "I am only in my twenties"; and "people don't get this when they are this age". Furthermore, some participants’ accounts also denoted the importance of resolving the ‘trauma’ associated with the moment that an illness diagnosis was revealed to them, as being an important component of adequately dealing with the illness experience. EFT

practitioner Abigail, for example, admitted to being interested in the specific details of the moments where diagnoses were revealed to her patients, e.g. “being in the car”, and “taking the call on the cell phone” where their diagnosis was revealed to them.

Regardless of the diversity of patient circumstances and needs, throughout all the participants’ accounts of using EFT to help patients come to terms with the illness experience, there was a common thread of the notion of ‘acceptance’. Participants’ accounts present the importance of promoting ‘acceptance’ in patients of their illness experiences and consequent limitations. Brattberg (2008) noted that EFT, similar to other psychotherapeutic interventions such as Cognitive Behaviour Therapy (CBT) and mindfulness, is based on the premise that acceptance of a situation rather than resistance to it, can help reduce suffering. Stanton, Revenson and Tennen (2007) suggested that psychological adjustment is often necessary for dealing with chronic illnesses. However, in order for psychological adjustment to take place, acceptance is first required (Taylor, 1983). Acceptance of a difficult situation or circumstance alludes to the willingness to experience current reality in a non-judgemental manner (Roemer & Orsillo, 2002). Indeed, McCracken, Carson, Eccleston et al. (2004) argued that contrary to avoidance, which may only give a false sense of control to patients, acceptance can assist patients make better health-related decisions.

In light of the view of a patient as a whole-person, this study suggests that patients may also benefit from the exploration of the existential or ‘symbolic’ meanings of their illness. In Chapter 2 (Literature Review), I discussed the concept of ‘symbolic disease’, which suggests that a disease is a somatic representation of the person’s life-world, including their life story, personal history and the meanings assigned to their life experiences. This model entails the notion of the ‘whole’ person, characterised by a reciprocity between physicality (‘body’) and subjectivity (‘mind’), wherein physicality and subjectivity of a disease are inter-connected and have resonances in each other (Broom, 2007). Wilberg (2011) also posited that the occurrence of a specific disease at a

specific time in a person's life represents or holds a particular meaning in the broader existential framework of the person's life-world.

Participants' accounts from my study illustrated that there may be therapeutic value in the exploration of patients' personal symbolic meanings of their illnesses. For example, participants of my study alluded to their illnesses as: being their body's 'call for attention and rest'; serving as a 'legitimate' excuse to avoid doing things they did not want to do; or as a 'boundary' from other people, among others. Participants' accounts suggested that by exploring these symbolic meanings of their illnesses, they were able to not only obtain psychological therapeutic value, but also inculcate more positive health behaviours into their lives. For instance, patients' view that their illness formerly served as a 'boundary' from other people and gave them an 'excuse to hide', led to the patients becoming more empowered to say 'no' to other people's demands.

#### **Summary: Recommendations for practice**

**EFT practitioners are recommended to help patients:**

- Address any unproductive feelings around the psycho-social limitations posed by their illness;
- Foster acceptance of self and any limitations faced in light of their illness; and
- Explore patients' personal symbolic meanings of their illnesses in an endeavour to promote more productive health behaviours.

#### ***Future: Moving towards Recovery***

Different from the notion of 'cure', which may imply an endpoint, the concept of 'recovery' has been explored in my study as both a 'journey', *and* a 'destination'. Slade et al. (2014) argued that 'recovery' is not necessarily about reaching a state of 'healthy normalcy', or no longer requiring medical/health support, or getting better; instead it is about "recovering a life" (p. 14). Additionally, participants' accounts in this study also suggested that the journey towards recovery from illness is often not a linear progression from illness to wellness; rather it is a 'spiral' process

whereby small improvements can be followed by relapses. My study's participants used expressions such as "waiting for the other shoe to drop" (Abigail, EFT practitioner), and "one step forward, two steps back" (Cassandra, CFS patient) to describe what may be considered as a difficult journey towards recovery. In light of what may be an often lengthy journey, characterised by disappointments and perceived setbacks, a sense of hope and positive expectation for recovery may assist patients better cope with their illness experience. Slade et al. (2014) argued that hope is a key process of recovery, and therefore promoting hopefulness in patients is crucial for supporting wellness.

In Chapter 2 (Literature Review), I discussed a multi-dimensional model of 'recovery' that includes existential recovery, improved sense of self, and personal empowerment, and social identity. The findings from my study also allude to the impact an illness can have on a patient's personal and social identity. Participants of this study noted that "an illness changes you" (Cassandra), and that a patient will never go back to being the person they were before they got sick (Alicia). These participant accounts allude to illness as having 'life-altering' impacts on patients' sense of self, ways of relating with others, as well as expectations from, and ways of engaging with life. In the case of my study, participants used EFT to support this readjustment.

Participants also suggested that this readjustment may not necessarily mean a reduction in their health and wellbeing when compared to their 'pre-illness' state. Rather, some participants alluded to the notion of 'personal growth', and valuable learnings obtained from what may otherwise be perceived as a negative illness experience. Some participants paradoxically even went so far as to say they were 'grateful' for having had the illness experience (Fleur), and that as a result of the illness, their whole way of living life had changed for the better (Kayley). Participants talked about becoming more empowered to live their lives on their own terms, living more in 'alignment'

with their personal values, and becoming more assertive in their relationships, following their use of EFT.

### **Summary: Recommendations for practice**

**EFT practitioners are recommended to help patients:**

- cultivate a sense of hope about the possibility of recovering and leading a productive life;
- reconstruct a new sense of personal and social identity in light of their illness experiences; and
- explore new healthful ways of relating with life and others.

### **Physical health of the patient as a whole-person**

The previous section provided a synthesis of my study's findings in relation to their implications for emotional health. The current section explores the study's implications for patients' physical health. It should be noted that the boundaries of emotional and physical health components as presented in my proposed model, are fluid. In Chapter 2 (Literature Review), I noted that my study is grounded in a holistic view of health, one that suggests that emotional and physical aspects interact with each other. Therefore, this model does not aim to prescribe mutually exclusive measures for emotional and physical health improvement. As such, the emotional and physical health aspects of my proposed model should be viewed in conjunction with each other. In the current section, I provide two main aspects of physical health improvement; firstly, the provision of psychological support for physical symptom management, and secondly, the notion of 'changing patients' personal relationship with their bodies'.

### *Facilitating symptom management through psychological support*

Participants' accounts from this study illustrate their experiences of using EFT to support physical symptom management. Both practitioner and patient participants' use of EFT for physical symptom management ranged from applying EFT at a physical symptom level without addressing associated feelings or emotions to using EFT to elevate patients' emotional state which in turn helped them with their pain perception. Participants also noted that they used EFT to deal with the side-effects associated with pharmacological/medical treatments of their diseases.

The idea of providing psychological support for symptom management has been discussed in the literature, and examined in both quantitative and qualitative studies. In Chapter 2 (Literature Review), I presented a sample of the literature discussing applications of psychological support for management of physical symptoms. Pain, for example, is a physical symptom widely studied in the context of psychotherapeutic interventions. Hamilton-West (2011) suggested that psychological interventions may be administered for pain management to patients following surgery.

Gatchel, Bo Peng, Peters, Fuchs and Turk (2007) presented a review of scientific research and developments in the biopsychosocial approach to chronic pain. Gatchel et al. (2007) suggested that pain was historically seen as a secondary symptom of tissue pathology, according to which the experienced and reported pain levels should be proportionate to the tissue pathology; however, this is not now considered to be the case. New models of pain have emerged which suggest that the pain experience is a subjective sensory experience, which is almost always unpleasant, making pain an emotional experience as well as a physical experience (Gatchel et al., 2007). Covic, Adamson, Spencer and Howe (2003) conducted a study involving 157 patients with rheumatoid arthritis, and found that feelings of helplessness, and the perception that the patient has no control over their disease can impact pain levels. Practitioner participant Rachel, described her experience

of using EFT on her clients' to "decrease their perception of pain and increase their ability to carry out their normal tasks of living in their daily lives".

Participants in this study discussed their application of EFT to not only pain, but also other physical symptoms such as skin itchiness (Donna), skin blisters (Taylor), and nausea (Abigail). Another practitioner participant Madeleine, illustrated her use of EFT to support improved limb and finger mobility in a client who had suffered a stroke, and a consequent loss of movement in his fingers and limbs. Psychotherapeutic interventions for addressing physical symptoms appears to have been discussed in the literature, however, primarily in the context of medically unexplained symptoms and psychosomatic disorders. Kleinstäuber, Witthöft and Hiller (2011) suggested that psychotherapy may assist the treatment of medically unexplained symptoms by promoting productive health beliefs and self-responsibility in patients, and improve patients' participation in their own healthcare.

Participants' accounts also illustrated their use of EFT for managing physical symptoms and side-effects associated with medical/pharmacological treatments for their illnesses. EFT practitioner Abigail, recounted her experience of using EFT to assist a client between her chemotherapy sessions to manage side-effects of chemotherapy such as exhaustion, nausea, and general distress. Another practitioner participant Donna, described a young client's self-administration of EFT before and after his spinal tap sessions for cancer to manage pain and itching associated with this procedure. Redd, Montgomery and Duhamel (2001) also suggested that behavioural interventions can be useful for alleviating side-effects of invasive biomedical treatments, such as anticipatory nausea, vomiting, anxiety, and pain.

### Summary: Recommendations for practice

EFT practitioners are recommended to provide psychological support to patients:

- to help improve their emotional state for alleviating perception of pain and other physical symptoms;
- for physical symptom management and promotion of productive health beliefs and self-responsibility; and
- management of side-effects associated with biomedical treatments.

### *Changing relationship with the body*

Participants of my study described their experiences of using EFT to change their relationship with their physical bodies. The emergent findings explored notions such as: ‘having compassion for the body’; ‘changing the mental image of the body’; ‘accepting the body’s limitations’; ‘listening to the body’; and ‘giving the body permission to heal’. Patient participants’ accounts often alluded to an anthropomorphic rendition of the physical body. Participants talked about their bodies as if the body had a conscious intelligence of its own, the ability to undertake informed action, and the ability to communicate or give messages to the person inhabiting the body. Physical symptoms were often portrayed in participants’ accounts as part of the body’s ‘language’. Fibromyalgia patient Candace, who admitted to always putting other’s needs before hers, noted that her illness was her body’s way of sending her signals, and asking her to “stop” and “give it attention”. The notion of physical symptoms being part of the body’s ‘language’ has also been discussed in literature (e.g. Wilberg, 2011; Broom et al., 12).

Participants also talked about their physical bodies, and the improvement of bodily health, as if viewing their bodily health as a project to be worked on. CFS patient Cassandra, recounted her experience of writing a vision statement for her body and health. Another patient participant Fleur, described her long-standing dislike of her physical body and appearance following a sexual abuse incident during childhood. A study conducted by Didie, Tortolani, Pope, Menard, Fay and



Phillips (2006) found that a large proportion of adults with body dysmorphic disorder (i.e. extreme distress over an imagined or small flaw in physical appearance) reportedly experienced abuse events during childhood. Fleur admitted to using EFT to cultivate greater compassion for her body. She also alluded to the notion of ‘allowing the body to heal itself’. Kayley, another CFS patient, even said that she saw healthfulness as the body’s default state, with illness being a representation of ‘something being in the way of the body being healthy’; that if the body is given the ‘chance’, it can heal itself.

The anthropomorphic rendition of the physical body has resonances in the concept of the ‘lived body’ as discussed in phenomenological literature. Wilberg (2011) described the lived body as a subjective embodiment and expression of a person’s consciousness. According to Wilberg (2011), the lived body represents a “living biological language” (p. 308), and symptoms are viewed as “messengers” (p. 208) of the patient’s story or subjective lived experience. Price (1993, p. 37) described the concept of ‘body-listening’ in people with chronic illness as “awareness of, and attention to an understanding and interpretation of one’s body”, colloquially referred to as “tuning into one’s body”. The participants of my study also spoke about being more ‘in tune’ with their bodies, developing greater self-awareness, bodily awareness, self-compassion, and general self-acceptance. By developing greater self-awareness of their bodily needs (e.g. more rest), practising compassion and acceptance for their body’s limitations, participants related being able to improve their general sense of well-being. Arthritis patient Rhea, for instance, noted with a sense of light-heartedness, “now it doesn't matter, if I can't do *vajrasana*”, when recounting her experience of facing difficulty practising certain yoga poses. Her laughter, in particular, exemplified her journey from ‘beating herself up’ about her bodily limitations to attaining a sense of acceptance and ‘being at peace’ with her current bodily health.

## Summary: Recommendations for practice

EFT practitioners are recommended to assist patients:

- foster compassion for their bodily limitations in light of their illness experience;
- develop greater self-awareness including awareness of personal and bodily needs; and
- promote a sense of acceptance for any bodily limitations.

As noted previously, my study is underpinned by the biopsychosocial view of health. Following the discussion of my study's implications for practice in the emotional and physical health spheres, the subsequent section explores my study's findings in the context of patients' social environment.

### The social environment

My proposed model views the patient as a whole-person as being situated within a social context or environment. In Chapter 2 (Literature Review), I discussed the WHO Determinants of Health. WHO presents seven main determinants of health namely, income and social status, education, physical environment (including infrastructure), social support networks, genetics (including personal health behaviours, coping mechanisms, and lifestyle habits), access to health services, and gender. In light of EFT's ability to be used for self-care, and administered by practitioners via telephone/online platforms, I also explored experiences of EFT in the context of some of the aforementioned determinants of health. Physical environment, access to health services, social support, and personal health behaviours/coping mechanisms were particularly pertinent in this exploration.

In my explorations of the notion of 'recovery', I posit that 'recovery' does not necessarily entail arriving at a 'pre-illness' normalcy; instead it may involve finding new ways of engaging with life, and may also require psycho-social readjustment. Slade et al. (2014) argued that promoting

recovery requires creation of “inclusive communities” (p. 14) that allow patients to easily access health and community support services. Participants’ accounts in my study illustrate the delivery of EFT via telephone, and online platforms, as a means of tackling geographic, and stigma-related barriers to access of support services. Some practitioner participants also described their experiences of providing social support to groups of patients through online platforms.

Additionally, Slade et al. (2014) alluded to the importance of empowering patients in self-management of their health and wellbeing with the aim of enhancing patients’ quality of life. Slade et al. (2014) suggested that self-management resources should include tools and strategies that patients can adopt for improving their day to day wellbeing, as well as for identifying and managing stress triggers. Indeed, participants’ accounts of EFT point towards the self-administration of EFT by patients for self-management, both as a preventative and reactive stress management measure.

#### **Summary: Recommendations for practice**

**EFT practitioners are recommended to:**

- offer psychological support services via telephone and online mediums for people facing geographical, stigma-related or other barriers to the access of support services;
- offer online support groups for patients suffering isolation; and
- impart self-management strategies to patients (e.g. EFT) for ongoing maintenance of their wellbeing.

Having presented a synthesis of the study’s emergent findings in my proposed healthcare model for the patient as a whole-person, I will now discuss the study’s limitations, provide recommendations for further research, and conclude this thesis.

## Limitations of study

As with any research, in light of time and resource restrictions, there are limitations associated with any study, which must be considered in interpreting the emergent findings. To my knowledge, the study had the following limitations:

- **Practitioner bias:** Half of my study's sample comprised EFT practitioners. Practitioners may have a personal bias towards the usefulness of EFT. They are likely to have a personal belief in the technique because offering this therapy forms their vocation. There may be a potential tendency to over-estimate the benefits of EFT. Practitioners very often discussed their understanding of their clients' experiences in describing their (practitioners') experiences of EFT. Practitioners' accounts of their clients' experiences cannot be equated with their clients' direct experiences.
- **Socio-demographic diversity of the participant sample:** As has been described in the study methodology, IPA studies require a homogenous participant sample. The homogeneity of the participant sample may often be derived from participants' socio-demographic criteria. However, for the purposes of this study, I did not place any socio-demographic criteria, apart from the requirement for patients to be at least 18 years of age. The decision to not restrict these inclusion criteria was made based on the fact that EFT is a contemporary technique, with a relatively nascent, albeit fast-growing evidence base and user group, when compared to other more established psychological support techniques such as CBT and mindfulness. Of particular importance among the socio-demographic characteristics of the participant sample in this study is the diversity of participants' countries of residence. Countries may vary quite broadly in their public healthcare systems and arrangements, which could influence the experiences of the study's participants.

- **Predominantly female sample:** My study sample comprised 14 female, one male and one non-binary participants. The patient sample in particular comprised all females. The predominance of females in the participant sample was not an intended outcome, nor was a feminist methodological basis for the study explored or considered - although it might be useful for explorations in further studies. From a different perspective, however, the predominantly female participant sample for this study can also be seen to increase the homogeneity of the sample. Additionally, it should also be noted that some researchers suggest that women are more likely to be impacted by long-term chronic illness, which can affect their quality of life (e.g. Abdelaziz, 2007).
- **Variety of chronic diseases:** For the same reason that inclusion criteria were not placed on the socio-demographic characteristics of participants, criteria were not placed on the 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. Having said that, an interesting observation is that many of the patient participants suffered from CFS.

### Recommendations for further research

As noted previously, my study explored experiences of EFT with the view to generate some findings in the context of generalised patient well-being, rather than disease-specific care. Researchers interested in conducting further research in this area may wish to explore experiences of EFT for specific chronic diseases. As noted previously, a large number of my study's patient participants suffered from CFS. Several practitioner participants also claimed to have worked with

clients suffering from CFS. As such, exploration of users' experiences of EFT for CFS may be a useful first step in further building the canon of academic literature on EFT and chronic illness.

Additionally, as noted in Chapter 3 (Methodology), specific socio-demographic inclusion/exclusion criteria in relation to place of residence, age, and gender were not placed on the participant sample. Further research may be conducted for patients of specific age-groups, gender, places of residence and other socio-demographic characteristics. Exploration of users' experiences of EFT for more homogenous participant samples may provide further insight into this technique's applicability for different patient populations.

Furthermore, this study explored users' experiences of EFT for chronic disease healthcare. The synthesis of the study's findings led to the generation of a healthcare model to assist the practice of EFT. Researchers may conduct similar studies to explore users' experiences of other emerging and established psychotherapeutic support techniques for supporting physical chronic disease healthcare. Additionally, researchers may explore the individual motifs presented in my proposed model discussed earlier in this chapter, in the context of other psychotherapeutic techniques. For example, researchers may explore users' experiences of employing another technique (e.g. mindfulness, or acceptance and commitment therapy) to foster compassion for bodily limitations, or reconstructing a new sense of self and promoting positive health beliefs in patients.

### **Concluding remarks**

My study explored, through a constructivist, interpretative phenomenological methodological paradigm, EFT experiences of eight EFT practitioners, and eight chronic disease patients. The aim of the study was to explore users' experiences of EFT for supporting chronic disease healthcare.

Using a biopsychosocial view of health, and a personhood approach to healthcare, this study puts forward the case for expanding our view of health, illness, and the patient.

Participants' accounts illustrate the therapeutic value of incorporating psychological support (in this case, EFT) for enhancing the emotional and physical health of chronic disease patients. The emergent findings illustrate an alternate view of illness as serving a purpose in the broader existential framework of patients' life-worlds, and posit how exploration of illness symbology can give meaning to patients and also facilitate cultivation of more productive health behaviours. Participants' accounts suggest that recovery may be a possibility even when cure may not. The study's findings allude to the notion of a 'spiral path' to recovery, and highlight the importance of fostering acceptance of illness-related psychosocial and bodily limitations in enhancing patient wellbeing. The application of EFT for self-care and its administration via tele-mental health applications point to the possibility of improving access to healthcare and support, and fostering greater personal empowerment in patients for self-care.

A common thread emerged across some very poignant constructions of the health, illness and recovery experiences of my study's participants; hope and possibility amid what may otherwise be often dark, excruciating, and isolating moments of illness. I therefore offer the reader these final words from one of my participants, Cassandra:

Each one of us is the possibility for anything ... We all are possibilities at every moment of our life. And just because I had been so sick didn't mean I couldn't be healthy again.

# References

---

Abdelaziz, F. B. (2007). Women's Health and Equity Indicators. *International Journal of Public Health*, 52(1), S1-S2. doi:10.1007/s00038-006-6045-y

Alexander, F. (1950). *Psychosomatic medicine*. New York: Norton Company.

Alwan, N., & Nawajah, Z. (2013). The Effectiveness of a Training Program Based on Emotional Freedom Technique in Upgrading Feelings of Happiness for Diabetics in Gaza. *Research on Humanities and Social Sciences*, 3(18), 6-17. Retrieved from [http://pakacademicsearch.com/pdf-files/art/448/6-17%20Vol%203,%20No%2018%20\(2013\).pdf](http://pakacademicsearch.com/pdf-files/art/448/6-17%20Vol%203,%20No%2018%20(2013).pdf)

Amos, I. (2016). Interpretative phenomenological analysis and embodied interpretation: Integrating methods to find the 'words that work'. *Counselling and Psychotherapy Research*, 16(4), 307–317. doi: 10.1002/capr.12094

Andrade, J., & Feinstein, D. (2004). Energy psychology: theory, indications, evidence. In D. Feinstein, *Energy psychology interactive* (Appendix, pp. 199-214). Ashland, OR: Innersource.

Anthony, W. A. (1993). Recovery from mental illness: the guiding vision of the mental health service system in the 1990. *Psychosocial Rehabilitation Journal*, 16(4), 11-23. doi: 10.1037/h0095655

Association for Comprehensive Energy Psychology (ACEP). (2016). *What is Energy Psychology?* Retrieved from



[http://c.ymcdn.com/sites/www.energypsych.org/resource/resmgr/definition\\_of\\_energy\\_psychol.pdf](http://c.ymcdn.com/sites/www.energypsych.org/resource/resmgr/definition_of_energy_psychol.pdf)

Aujoulat, I., Marcolongo, R., Bonadiman, L., & Deccache A. (2008). Reconsidering patient empowerment in chronic illness: A critique of models of self-efficacy and bodily control. *Social Science & Medicine*, 66(5), 1228-1239. doi: 10.1016/j.socscimed.2007.11.034

Babamahmoodi, A., Arefnasab, Z., Noorbala, A. A., Ghanei, M., Babamahmoodie, F., Alipour, A., . . . Darabi, H. (2015). Emotional Freedom Technique (EFT) effects on psycho-immunological factors of chemically pulmonary injured veterans. *Iranian Journal of Allergy, Asthma and Immunology*, 14(1), 37-47. Retrieved from <http://ijaai.tums.ac.ir/index.php/ijaai/article/view/414>

Baker, B. S., & Hoffman, C. J. (2014). Emotional Freedom Techniques (EFT) to reduce the side effects associated with tamoxifen and aromatase inhibitor use in women with breast cancer: A service evaluation. *European Journal of Integrative Medicine*, 7(2), 136-142. doi: 10.1016/j.eujim.2014.10.004.

Baker, A. H., & Siegel, M. A. (2010). Emotional Freedom Techniques (EFT) reduces intense fears: A partial replication and extension of Wells et al. *Energy Psychology: Theory, Research, and Treatment*, 2(2), 13–30. doi: 10.9769/EPJ.2010.2.2.AHB.

Barbour, R. (2008). *Introducing qualitative research: a student's guide to the craft of doing qualitative research* (1<sup>st</sup> edition). London: Sage Publications Ltd.

Beck, A. T. (1964). Thinking and Depression. *Theory and Therapy*, 10(6), 561-571. doi: 10.1001/archpsyc.1964.01720240015003.

Benor, D. J., Ledger, K., Toussaint, L., Hett, G., & Zaccaro, D. (2009). Pilot study of emotional freedom techniques, wholistic hybrid derived from eye movement desensitization and reprocessing and emotional freedom techniques, and cognitive behavioral therapy for treatment of test anxiety in university students. *Explore: The Journal of Science and Healing*, 5, 338-340. doi:10.1016/j.explore.2009.08.001.

Bharathan, J. (2014). EFT Benefits: Resolving Fear Improves Blood Pressure. EFT Universe. Retrieved from <http://www.eftuniverse.com/phobias-fears/eft-benefits-resolving-fear-improves-blood-pressure-and-cholesterol-levels>

Biggerstaff, D., & Thompson, A. (2008). Interpretative Phenomenological Analysis (IPA): A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology*, 5(3), 214-224. doi: 10.1080/14780880802314304.

Blumer, H. (1969). *Symbolic Interactionism: Perspective and Method*. Englewood Cliffs, NJ: Prentice Hall.

Boath, E., & Rolling, C. (2015). Echoes in Bosnia and Beyond. *Somatic Psychotherapy Today*, 5(4), 38-41.

Boath, E., Stewart, A., & Carryer, A. (2012a). A narrative systematic review of the effectiveness of Emotional Freedom Techniques (EFT). *Staffordshire University, CPSI Monograph, Centre for Practice and Service Improvement*.

Boath, E., Stewart, A., & Carryer, A. (2012b). Tapping for PEAS: Emotional Freedom Technique (EFT) in reducing Presentation Expression Anxiety Syndrome (PEAS) in University students. *Innovative Practice in Higher Education*, 1(2), 1-12.

Boath, E., Stewart, A., & Carryer, A. (2013). Tapping for success: A pilot study to explore if emotional freedom techniques (EFT) can reduce anxiety and enhance academic performance in university students. *Innovative Practice in Higher Education*, 1(3), 1-13.

Bohart A. (2000). The client is the most important common factor: clients' self-healing capacities and psychotherapy. *Journal of Psychotherapy Integration*, 10(2):127–149.

Bougea, A. M., Spandideas, N., Alexopoulos, E. C., Thomaides, T., Chrousos, G. P., & Darviri, C. (2013). Effect of the Emotional Freedom Technique on perceived stress, quality of life, and cortisol salivary levels in tension-type headache sufferers: A randomized controlled trial. *Explore: The Journal of Science and Healing*, 9(2), 91–99. doi:10.1016/j.explore.2012.12.005.

Boyd, K. (2000). Disease, illness, sickness, health, healing and wholeness: exploring some elusive concepts. *Medical Humanities*, 26(1), 9-17. doi:10.1136/mh.26.1.9.

Bramley, N., & Eatough, V. (2005). The experience of living with Parkinson's disease: An interpretative phenomenological analysis case study. *Psychology & Health*, 20(2), 223-235. doi: 10.1080/08870440412331296053.

Brattberg, G. (2008). Self-administered EFT (Emotional Freedom Techniques) in Individuals with Fibromyalgia: A Randomized Trial. *Integrative Medicine*, 7(4), 30-35.

- Brocki, J., & Wearden, A. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, 21(1), 87-108.
- Broom, B.C. (2002). Somatic metaphor: a clinical phenomenon pointing to a new model of disease, personhood, and physical reality. *Advances in Mind/Body Medicine*, 18(1), 16-29.
- Broom, B.C. (2007). *Meaning-full disease: How personal experience and meanings initiate and maintain physical illness*. London: Karnac Books.
- Broom, B., Booth, R., & Schubert, C. (2011). Symbolic Disease and Mind-body Co-emergence: A Challenge for Psychoneuroimmunology. *Explore*, 8(1), 16-25.
- Buckley, A., Corless, L., & Mee, S. (2016). Using patient stories to reflect on care. *Nursing Times*, 112(10), 22-25. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/27141722>
- Burk, L. (2010). Single session EFT (Emotional Freedom Techniques) for stress-related symptoms after motor vehicle accidents. *Energy Psychology: Theory, Research, & Treatment*, 2(1), 65-71.
- Büssing, A. & Koenig, H. (2010). Spiritual Needs of Patients with Chronic Diseases. *Religions*, 18(27), 18-27.
- Carrington, P. (2012). History of Meridian Tapping. East Milestone, New Jersey: Pace Educational Systems Inc. Retrieved from <http://masteringeft.com/masteringblog/about-eft/history-of-eft/>

Carter, S. M., & Little, M. (2007). Justifying Knowledge, Justifying Method, Taking Action: Epistemologies, Methodologies, and Methods in Qualitative Research. *Qualitative Health Research*, 17(10), 1316-1328. doi: 10.1177/1049732307306927.

Centre for Clinic Interventions (CCI). (2014). *What are Core Beliefs?* Department of Health, Northbridge, Western Australia. Retrieved from <http://www.cci.health.wa.gov.au/docs/ACF3B8A.pdf>

Chanfrault-Duchet, M. F. (1991). Narrative Structures, Social Models, and Symbolic Representation in the Life Story. In Gluck, S. B. & Patai, D. (Eds.), *Women's Words: The Feminist Practice of Oral History*. New York, NY: Routledge.

Chatwin, H., Stapleton, P., Porter, B., Devine, S., & Sheldon, T. (2016). The Effectiveness of Cognitive Behavioral Therapy and Emotional Freedom Techniques in Reducing Depression and Anxiety Among Adults: A Pilot Study. *Integrative Medicine (Encinitas)*, 15(2), 27-34.

Church, D. (2009a). The Effect of EFT (Emotional Freedom Techniques) on Athletic Performance: A Randomized Controlled Blind Trial. *The Open Sports Sciences Journal*, 2, 94-99. doi: 10.2174/1875399X00902010094.

Church, D. (2009b). The treatment of combat trauma in veterans using EFT (Emotional Freedom Techniques): A pilot protocol. *Traumatology*, 15(4).

Church D. (2013a) Clinical EFT as an Evidence-Based Practice for the Treatment of Psychological and Physiological Conditions. *Psychology*, 4(8), 645-654.

Church, D. (2013b). *The EFT manual* (3rd edition). Santa Rosa (CA): Energy Psychology Press.

*Tapping into Recovery: Exploring Experiences of EFT*

Church, D., & Brooks, A. J. (2010). The effect of a brief EFT (Emotional Freedom Techniques) self-intervention on anxiety, depression, pain and cravings in healthcare workers. *Integrative Medicine: A Clinician's Journal*, 9(5), 40–43. Retrieved from <https://s3.amazonaws.com/eft-academic-articles/HealthCare.pdf>

Church, D., & Brooks, A. J. (2013). The effect of EFT (Emotional Freedom Techniques) on psychological symptoms in addiction treatment: A pilot study. *Journal of Scientific Research and Reports*, 2(1), 315-323. doi:10.9734/JSRR/2013/3500.

Church, D., & Brooks, A. J. (2014). CAM and energy psychology techniques remediate PTSD symptoms in veterans and spouses. *Explore: The Journal of Science and Healing*, 10(1), 24-33. doi:10.1016/j.explore.2013.10.006.

Church, D., De Asis, M., & Brooks, A. (2012). Brief Group Intervention Using Emotional Freedom Techniques for Depression in College Students: A Randomized Controlled Trial. *Depression Research and Treatment*, 2012(2012), 1-7. doi: 10.1155/2012/257172.

Church, D., & Downs, D. (2012). Sports confidence and critical incident intensity after a brief application of Emotional Freedom Techniques: A pilot study. *The Sport Journal*, 15(2012). Retrieved from <http://goo.gl/jsksgW>

Church, D., & Feinstein, D. (2013). Energy psychology in the treatment of PTSD: Psychobiology and clinical principles. In Van Leeuwen, T., & Brouwer M. (Eds.), *Psychology of trauma* (pp. 211–224). Hauppauge, NY: Nova Science Publishers.

Church, D., Geronilla, L., & Dinter, I. (2009). Psychological symptom change in veterans after *Tapping into Recovery: Exploring Experiences of EFT*

six sessions of EFT (Emotional Freedom Techniques): an observational study. *International Journal of Healing and Caring*, 9(1), 1-13.

Church, D., Hawk, C., Brooks, A., Toukolehto, O., Wren, M., Dinter, I., & Stein, P. (2013). Psychological Trauma Symptom Improvement in Veterans Using Emotional Freedom Techniques: A Randomized Controlled Trial. *The Journal of Nervous and Mental Disease*, 201(2), 153-60. doi: 10.1097/NMD.0b013e31827f6351.

Church, D., & Marohn, S. (2013). *Clinical EFT Handbook: A definitive resource for practitioners, scholars, clinicians and researchers* (2<sup>nd</sup> edition). Fulton, CA: Energy Psychology Press.

Church, D., & Nelms, J. (2016). Pain, range of motion, and psychological symptoms in a population with frozen shoulder: A randomized controlled dismantling study of Clinical EFT (Emotional Freedom Techniques). *Archives of Scientific Psychology*, 4(1), 38-48. doi:10.1037/arc0000028.

Church, D., & Palmer-Hoffman, J. (2014). TBI symptoms improve after PTSD remediation with Emotional Freedom Techniques. *Traumatology*, 20(3), 172–181. Retrieved from <https://eft-research.s3.amazonaws.com/TBI%20Symptoms%20Improve%20After%20PTSD%20Remediation%20With%20Emotional%20Freedom%20Techniques.pdf>

Church, D., Piña, O., Reategui, C., & Brooks, A. J. (2012). Single session reduction of the intensity of traumatic memories in abused adolescents: A randomized controlled trial. *Traumatology*, 18(3), 73-79. doi: 10.1177/1534765611426788.

Church, D., Yount, G., & Brooks, A. (2012b). The Effect of Emotional Freedom Techniques on *Tapping into Recovery: Exploring Experiences of EFT*

Stress Biochemistry: A Randomized Controlled Trial. *The Journal of Nervous and Mental Disease*, 200(10), 891-896. doi: 10.1097/NMD.0b013e31826b9fc1.

Church, D., Yount, G., Rachlin, K., Fox, L., & Nelms, J. (2016). Epigenetic effects of PTSD remediation in veterans using Clinical EFT (Emotional Freedom Techniques): A randomized controlled pilot study. *American Journal of Health Promotion*, 1-11. doi:10.1177/0890117116661154.

Clancy, M. (2013). Is reflexivity the key to minimising problems of interpretation in phenomenological research? *Nurse Researcher*, 20(6), 12-16.

Clond, M. (2016). Emotional Freedom Techniques for anxiety: A systematic review with meta-analysis. *Journal of Nervous and Mental Disease*, 204, 388–395.

Cooley, C. H. (1902). *Human Nature and the Social Order*. New York, NY: Scribner.

Cordes, S. (1985). Biopsychosocial Imperatives from the Rural Perspective. *Social Science and Medicine Journal*, 21(12), 1373-1379.

Costley C., Elliott G., & Gibbs P. (2010). *Doing Work Based Research Approaches to Enquiry for Insider-Researchers*. London: SAGE Publications Ltd.

Coulter, A. (2013). Understanding the experience of illness and treatment. In Ziebland, S., Coulter, A., Calabrese, J. & Locock, L. (Eds.), *Understanding and Using Health Experiences: Improving patient care* (pp. 1849-1919). Oxford: Oxford Scholarship Online.



Covic, T., Adamson, B., Spencer, D., & Howe, G. (2003). A biopsychosocial model of pain and depression in rheumatoid arthritis: a 12-month longitudinal study. *Rheumatology*, 42(11), 1287-1294. doi: 10.1093/rheumatology/keg369.

Craig, G., Bach, D., Groesbeck, G., & Benor, D. J. (2009). Emotional Freedom Techniques (EFT) for traumatic brain injury. *International Journal of Healing and Caring*, 9(2), 1-12.

Craig, G., & Fowle, A. (1995). *Emotional freedom techniques: the manual*. Sea Ranch (CA): Gary Craig.

Crotty, M. (1998). *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London: SAGE Publications Ltd.

Cudney, S., Butler, M., Weinert, C., & Sullivan, T. (2002). Ten Rural Women Living with Fibromyalgia Tell It Like It Is. *Holistic Nursing Practice*, 16(3), 35-45.

Cunningham, A., & Watson, K. (2004). How Psychological Therapy May Prolong Survival in Cancer Patients: New Evidence and a Simple Theory. *Integrative Cancer Therapies*, 3(3), 214-229.

Davidhizar, R. (1994). The pursuit of illness for secondary gain. *The Healthcare Supervisor*, 13(1), 10-15.

Davis, D. A., Luecken, L. J., & Zautra, A. J. (2005). Are Reports of Childhood Abuse Related to the Experience of Chronic Pain in Adulthood?: A Meta-analytic Review of the Literature. *Clinical Journal of Pain*, 21(5), 398-405. doi: 10.1097/01.ajp.0000149795.08746.31.

Denzin, N., & Lincoln, Y. (2008). *Collecting and Interpreting Qualitative Materials* (3<sup>rd</sup> Edition). London: Sage Publications Ltd.

Department of Health (DoH). (2012). *Chronic Disease*. Commonwealth of Australia. Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/Content/chronic#def>

Department of Health (DoH). (2015). *Better Outcomes for People with Chronic and Complex Health Conditions: Report of the Primary Healthcare Advisory Group* (ISBN: 978-1-76007-252-0). Retrieved from [https://www.health.gov.au/internet/main/publishing.nsf/Content/76B2BDC12AE54540CA257F72001102B9/\\$File/Primary-Health-Care-Advisory-Group\\_Final-Report.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/76B2BDC12AE54540CA257F72001102B9/$File/Primary-Health-Care-Advisory-Group_Final-Report.pdf)  
<https://www.ncbi.nlm.nih.gov/pubmed/22490300>

De Ridder, D., Geenen, R., Kuijer, R., & Van Middendorp, H. (2008). Psychological adjustment to chronic disease. *Lancet*, 372(9634), 246–255.

Descartes, R. (1952). Meditations on the first philosophy. In: R. M. Hitchins (Ed.), *Great Books of the Western World*. New York, NY: Encyclopaedia Britannica.

Didie, E. R., Tortolani, C. C., Pope, C. G., Menard, W., Fay, C., & Phillips, K. A. (2006). Childhood abuse and neglect in body dysmorphic disorder. *Child Abuse & Neglect*, 30(10), 1105–1115. doi: 10.1016/j.chiabu.2006.03.007

Diepold, J.H., & Goldstein, D. M. (2009). Thought field therapy and qEEG changes in the treatment of trauma: A case study. *Traumatology*, 15(1), 85-93.

Edirippulige, S., Levandovskaya, M., & Prishutova, A. (2013). A qualitative study of the use of Skype for psychotherapy consultations in the Ukraine. *Journal of Telemedicine and Telecare*, 19(7), 376–378.

EFT Universe (2014). *Clinical EFT*, EFTUniverse.com. Retrieved from [http://www.eftuniverse.com/index.php?option=com\\_content&view=article&id=9010](http://www.eftuniverse.com/index.php?option=com_content&view=article&id=9010)

EFT Universe (2017). *Experience the Magic of EFT!* Retrieved from <http://www.eftuniverse.com/faqs/eft-and-tapping-hundreds-of-case-studies>

Engel, G. (1977). The need for a new medical model: a challenge for biomedicine. *Science*, 196(4286), 129–136.

Farkas, M. (2007). The vision of recovery today: what it is and what it means for services. *World Psychiatry*, 6(4), 68-74.

Feast, L. & Melles, G. (2010, July). *Epistemological Positions in Design Research: A Brief Review of the Literature*. Paper presented at the 2<sup>nd</sup> International Conference on Design Education, University of New South Wales, Sydney.

Feinstein, D. (2010). Rapid Treatment of PTSD: Why Psychological Exposure with Acupoint Tapping May Be Effective. *Psychotherapy: Theory, Research, Practice, Training*, 47(3), 385-402.

Feinstein, D., & Church, D. (2010). Modulating gene expression through psychotherapy: The contribution of non-invasive somatic interventions. *Review of General Psychology*, 14(4), 283–295.

Fishbain, D., Rosomoff, H., Cutler, R., & Rosomoff, R. (1995). Secondary Gain Concept: A Review of the Scientific Evidence. *The Clinical Journal of Pain*, 11(1), 6-21.

Flegal, K. (2015). EFT Helps Type I Diabetes: Blood Sugar Level Goes from 300 to 115. EFT Universe. Retrieved from <http://www.eftuniverse.com/chronic-illnesses/eft-helps-type-i-diabetes-blood-sugar-level-goes-from-300-to-115>

Gaesser, A. H. (2014). *Interventions to reduce anxiety for gifted children and adolescents* (Doctoral Dissertation). Retrieved from <http://digitalcommons.uconn.edu/cgi/viewcontent.cgi?article=6622&context=dissertations>

Gatchel, R. J., Peng, Y. B., Peters, M. L., Fuchs, P. N., & Turk, D. C. (2007). The Biopsychosocial Approach to Chronic Pain: Scientific Advances and Future Directions. *Psychological Bulletin*, 133(4), 581– 624. doi: 10.1037/0033-2909.133.4.581.

Gergen, K., & Gergen, M. (2008b). Social construction and research as action. In Reason, P. & Bradbury, H. (Eds.), *The Sage handbook of action research: Participative inquiry and practice* (2nd edition) (pp. 159-171). Thousand Oaks, CA: Sage Publications Ltd.

Geronilla, L., McWilliams, M., Clond, M. (2014, April). *EFT (emotional freedom techniques) remediates PTSD and psychological symptoms in veterans: a randomized controlled replication trial*. Presented at the Grand Rounds, Fort Hood, Killeen, Texas.

Green, J., & Thorogood, N. (2014). *Qualitative Methods for Health Research* (3<sup>rd</sup> Edition). London: Sage Publications Ltd.

Greene, M. J. (2014). On the Inside Looking In: Methodological Insights and Challenges in Conducting Qualitative Insider Research. *The Qualitative Report*, 19(29), 1-13. Retrieved from <http://nsuworks.nova.edu/cgi/viewcontent.cgi?article=1106&context=tqr>

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice*, 21(5), 372–278.

Grey, D. (2014). *Doing Research in the Real World* (3<sup>rd</sup> Edition). London: SAGE Publications Ltd.

Guest, G., Namey, E., & Mitchell, M. (2013). *Collecting Qualitative Data: A Field Manual for Applied Research*. London: Sage Publications Ltd.

Gulliver, A., Griffiths, K., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry*, 10(113), 1–9.

Gurret, J. M., Caufour, C., Palmer-Hoffman, J., & Church, D. (2012). Post-earthquake rehabilitation of clinical PTSD in Haitian seminarians. *Energy Psychology: Theory, Research, and Treatment*, 4(2), 33-40.

Hack, T. F., Degner, L. F., Watson, P., & Sinha L. (2006). Do patients benefit from participating in medical decision making? Longitudinal follow-up of women with breast cancer. *Psychooncology*, 15(1), 9-19. doi: 10.1002/pon.907.

Hailey, D., Roine, R., & Ohinmaa, A. (2008). The effectiveness of telemental health applications: A review. *Canadian Journal of Psychiatry*, 53(11), 769–778.

Hajloo, M., Ahadi, H., Rezabakhsh, H., & Mojembari A. (2014). Investigation on Emotional-Freedom Technique Effectiveness in Diabetic Patients' Blood Sugar Control. *Mediterranean Journal of Social Sciences*, 5(27), 1280-1285. doi: 10.5901/mjss.2014.v5n27p1280.

Hamilton-West, K. (2011). *Psychobiological Processes in Health and Illness*. London: Sage Publications Ltd.

Harper, M. (2012). Taming the amygdala: An EEG analysis of exposure therapy for the traumatised. *Traumatology*, 18(2), 61-74.

Hartung, J., & Stein, P. (2012) Telephone delivery of EFT remediates PTSD symptoms in veterans. *Energy Psychology: Theory, Research, and Treatment*, 4(1), 33-40.

Harvey, S., & Ismail, K. (2008). Psychiatric aspects of chronic physical disease. *Psychiatric Aspects of General Medicine*, 36(9), 471-474. doi: 10.1016/j.mpmed.2008.07.003.

Haugli, L., Strand, E., & Finset, A. How do patients with rheumatic disease experience their relationship with their doctors?: A qualitative study of experiences of stress and support in the doctor–patient relationship. *Patient Education and Counseling*, 52(2), 169-174. doi: 10.1016/S0738-3991(03)00023-5.

Hawkins, J., & Lindsay, E. (2006). We listen but do we hear? The importance of patient stories. *British Journal of Community Nursing*, 11(9), S6-S14. doi: 10.12968/bjcn.2006.11.Sup4.21767.

Hefferon, K., Grealey, M., & Mutrie, N. (2009). Post-traumatic growth and life threatening

physical illness: A systematic review of the qualitative literature. *British Journal of Health Psychology*, 14, 343–378. doi: 10.1348/135910708X332936.

Heinrich, M., Monstadt, D., & Michel, C. (2009). Psychologische Interventionen in der Behandlung chronischer Rückenschmerzen. *Der Orthopäde*, 38(10), 937-942. doi: 10.1007/s00132-009-1486-7.

Hewitt-Taylor, J. (2002). Inside knowledge: issues in insider research. *Nursing Standard*, 16(46), 33-35. doi: 10.7748/ns2002.07.16.46.33.c3239.

Hockey J., (1993). Research methods - researching peers and familiar settings. *Research Papers in Education*, 8(2), 199-225. doi: 10.1080/0267152930080205.

Hodge, P. M., & Jurgens, C. Y. (2011). A pilot study of the effects of Emotional Freedom Techniques in psoriasis. *Energy Psychology: Theory, Research and Treatment*, 3(2), 13–24.

Holman, H., & Lorig, K. (2000). Patients as partners in managing chronic disease. *British Medical Journal*, 320(7234), 526. doi: 10.1136/bmj.320.7234.526.

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, 52(4), 482-485.

Jain, S., & Rubino, R. (2012). The Effectiveness of Emotional Freedom Techniques for Optimal Test Performance. *Energy Psychology: Theory, Research and Treatment*, 4(2), 15-25.

Jamison, J. (1999). A Psychological Profile of Fibromyalgia Patients: A Chiropractic Case Study. *Journal of Manipulative and Physiological Therapeutics*, 22(7), 454-457.

Jones, M. J., & Brader-Araje, L. (2002). The Impact of Constructivism on Education: Language, Discourse, and Meaning. *American Communication Journal*, 5(3), 1-10. Retrieved from <http://ac-journal.org/journal/vol5/iss3/special/jones.pdf>

Jones, S. J., Thornton, J. A., & Andrews, H. B. (2011). Efficacy of Emotional Freedom Techniques (EFT) in Reducing Public Speaking Anxiety: A Randomized Controlled Trial. *Energy Psychology: Theory, Research, & Treatment*, 3(1), 19-32.

Jong, K., Vale, P., & Armstrong, B. (2005). Rural inequalities in cancer care and outcome. *Medical Journal of Australia*, 182(1), 13-14.

Karatzias, T., Power, K., Brown, K., McGoldrick, T., Begum, M., Young, J., ... Adams, S. (2011). A controlled comparison of the effectiveness and efficiency of two psychological therapies for posttraumatic stress disorder: eye movement desensitization and reprocessing vs. emotional freedom techniques. *The Journal of Nervous and Mental Disease*, 199(6), 372-378. doi: 10.1097/NMD.0b013e31821cd262.

Kitto, S., Chesters, J., & Grbich, C. (2008). Quality in qualitative research Criteria for authors and assessors in the submission and assessment of qualitative research articles for the Medical Journal of Australia. *Medical Journal of Australia*, 188(4), 243-246.

Kleinman, A. (1988). *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York, NY: Basic Books.



Kleinstäuber, M., Witthöft, M., & Hiller, W. (2011). Efficacy of short-term psychotherapy for multiple medically unexplained physical symptoms: A meta-analysis. *Clinical Psychology Review*, 31(1), 146-160. doi: 10.1016/j.cpr.2010.09.001.

Lamers, S., Bolier, L., Westerhof, G.J., Smit, F., & Bohlmeijer, E. (2012). The impact of emotional well-being on long-term recovery and survival in physical illness: a meta-analysis. *Journal of Behavioural Medicine*, 35(5), 538-547. doi: 10.1007/s10865-011-9379-8.

Larkin, M., & Griffiths, M. (2004). Dangerous Sports and Recreational Drug-use: Rationalizing and Contextualizing Risk. *Journal of Community & Applied Social Psychology*, 14(4), 215–232.

Larkin, M., Watts, S., Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3(2) 102-120.

Lee, J. H., Chung, S. Y., & Kim, J. W. (2015). A comparison of Emotional Freedom Techniques–Insomnia (EFT-I) and Sleep Hygiene Education (SHE) in a geriatric population: A randomized controlled trial. *Energy Psychology: Theory, Research, and Treatment*, 7(1), 1–8. doi:10.9769/EPJ.2015.07.01.JL.

Liamputtong P., & Ezzy D. (2005). *Qualitative Research Methods* (2nd Edition). South Melbourne, Victoria: Oxford University Press.

Liberman, R. P., & Kopelowicz, A. (2005). Recovery from schizophrenia: a concept in search of research. *Psychiatric Services*, 56(6), 735-742. doi: 10.1176/appi.ps.56.6.735

- Llewellyn-Edwards, T., & Llewellyn-Edwards, M. (2012). The effect of EFT (Emotional Freedom Techniques) on soccer performance. *Fidelity: Journal for the National Council of Psychotherapy*, 47, 14–19.
- Lorig, K. R., Ritter, P., Stewart, A. L., Sobel, D. S., William, B., Byron, J., ... Holman, H. (2001). Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes. *Medical Care*, 39(11), 1217-1223. doi: 10.1097/00005650-200111000-00008.
- Lubin, H., & Schneider, T. (2009). Change Is Possible: EFT (Emotional Freedom Techniques) with Life-Sentence and Veteran Prisoners at San Quentin State Prison. *Energy Psychology: Theory, Research, and Treatment*, 1(1). doi: 10.9769/EPJ.2009.1.1.HL.
- Mackereth, P. A. (1999). An introduction to catharsis and the healing crisis in reflexology. *Complementary Therapies in Nursing and Midwifery*, 5(3), 67-74. doi: 10.1016/S0738-3991(03)00023-5.
- Maharaj, M. E. (2016). Differential gene expression after Emotional Freedom Techniques (EFT) treatment: A novel pilot protocol for salivary mRNA assessment. *Energy Psychology: Theory, Research, and Treatment*, 8(1), 17–32. doi:10.9769/EPJ.2016.8.1.MM.
- Mahony, M., & Granvold, D. (2005). Constructivism and psychotherapy. *World Psychiatry*, 4(2), 74–77. Retrieved from viewed <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414735/>
- McCallion, F. (2012). Emotional Freedom Techniques for Dyslexia: A Case Study. *Energy Psychology: Theory, Research, and Treatment*, 4(2). doi:10.9769/EPJ.2012.4.2.FM.

McCracken, L., Carson, J., Eccleston, C., & Keefe, F. (2004). Acceptance and change in the context of chronic pain. *Pain*, 109(1-2), 4-7. doi: 10.1016/j.pain.2004.02.006.

McEwen, B. S., & Seeman, T. (1999). Protective and damaging effects of mediators of stress: elaborating and testing the concepts of allostasis and allostatic load. *Annals of the New York Academy of Science*, 896, 30-47. doi: 10.1111/j.1749-6632.1999.tb08103.x.

McEwen, B. S., & Stellar, E. (1993). Stress and the individual: mechanisms leading to disease. *Archives of Internal Medicine*, 153(18), 2093-2101. doi: 10.1001/archinte.153.18.2093.

Mead, G. H. (1934). *Mind, self, and society*. Chicago, IN: University of Chicago Press.

Mead, N., & Bower, P. (2000). Patient-centeredness: a conceptual framework and review of the empirical literature. *Social Science & Medicine*, 51(7), 1087-1110. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/11005395>

Mehta, N. (2011). Mind-body Dualism: A critique from a Health Perspective. *Mens Sana Monographs*, 9(1), 202–209. doi: 10.4103/0973-1229.77436

Merleau-Ponty, M. (1964). Eye and mind. In J. M. Edie (Ed.) *The Primacy of Perception*. Evanston: Northwestern University Press.

Multi-Health Systems Inc. MHS (2014). *Symptom Assessment-45 Questionnaire*. Retrieved from <http://www.mhs.com/product.aspx?gr=cli&id=overview&prod=sa45>

Mueser, K., Corrigan, P., Hilton, D., Tanzman, B., Schaub, A., Gingerich, S., ... Herz, M. (2002). Illness management and recovery: a review of the research. *Psychiatric Services*, 53(10), 1272-84.doi: 10.1176/appi.ps.53.10.1272.

National Centre for Complementary and Alternative Medicine (NCCAM). (2010). *Traditional Chinese Medicine: An Introduction*. National Institutes of Health, US Department of Health and Human Services. Retrieved from <http://nccam.nih.gov/health/whatiscam/chinesemed.htm?nav=gsa>

National Registry of Evidence-based Programs and Practices (NREPP). (2016). *Thought Field Therapy for the Treatment of Post-Traumatic Stress Symptoms*. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=60>

Neimeyer, R. A. (1993). An appraisal of constructivist psychotherapies. *Journal of Consulting and Clinical Psychology*, 61(2), 221–234. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/8473576>

Nelms, J., & Castel, D. (2016). A systematic review and meta-analysis of randomized and non-randomized trials of Emotional Freedom Techniques (EFT) for the treatment of depression. *Explore: Journal of Science and Healing*, 12(16), 416–426.

Nkwi, P., Nyamongo, I., & Ryan, G. (2001). *Field research into socio-cultural issues: Methodological guidelines*. Cameroon: International Center for Applied Social Sciences, Research, and Training.

Ortner, N., Palmer-Hoffman, J., & Clond, M. A. (2014). Effects of Emotional Freedom Techniques (EFT) on the reduction of chronic pain in adults: A pilot study. *Energy Psychology: Theory, Research, and Treatment*, 6(2), 14–21. doi:10.9769.EPJ.2014.6.2.NO.

Palmer-Hoffman, J., & Brooks, A. J. (2011). Psychological symptom change after group application of emotional freedom techniques (EFT). *Energy Psychology: Theory, Research, & Treatment*, 3, 33-38. Retrieved from [http://www.scirp.org/\(S\(vtj3fa45qm1ean45vvffcz55\)\)/reference/ReferencesPapers.aspx?ReferenceID=905522](http://www.scirp.org/(S(vtj3fa45qm1ean45vvffcz55))/reference/ReferencesPapers.aspx?ReferenceID=905522)

Pascale, C. (2011). *Cartographies of Knowledge: Exploring Qualitative Epistemologies*. Washington D.C: SAGE Publications Inc.

Pennebaker, J. W., Kiecolt-Glaser, J. K., & Glaser, R. (1988). Disclosure of traumas and immune function: Health implications for psychotherapy. *Journal of Consulting and Clinical Psychology*, 56(2), 239-245. doi: 10.1037/0022-006X.56.2.239.

Perkins, R. (2012). UK mental health policy development – An alternative view. In: Phillips, P., Sandford, T. & Johnston, C. (Eds.), *Working in mental health: practice and policy in a changing environment* (pp. 14-24). Oxford: Routledge.

Peterson, C., Park, N., & Seligman, M. (2006). Greater strengths of character and recovery from illness. *The Journal of Positive Psychology*, 1(1), 17-26. doi: 10.1080/17439760500372739.

Piaget, J. (1967). *Biologie et connaissance (Biology and knowledge)*. Paris: Gallimard.

Piaget, J. (1970). *Logic and psychology* (translation, W. Mays). New York, NY: Basic Books.

Piaget, J., & Cook, M. T. (1952). *The origins of intelligence in children*. New York, NY: International University Press.

Price, M. J. (1993). Exploration of body listening: health and physical self-awareness in chronic illness. *Advances in Nursing Science*, 15(4), 37-52. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/8512303>

Printz, C. (2013). Rural women with breast cancer less likely to receive radiotherapy. *Cancer*, 119(21), 741.

Redd, W., Montgomery, G., & Duhamel, K. (2001). Behavioral intervention for cancer treatment side effects. *Journal of the National Cancer Institute*, 93(11), 810-823. doi: 10.1093/jnci/93.11.810

Roemer, L., & Orsillo, S. M. (2002). Expanding Our Conceptualization of and Treatment for Generalized Anxiety Disorder: Integrating Mindfulness/Acceptance- Based Approaches With Existing Cognitive- Behavioral Models. *Clinical Psychology: Science and Practice*, 9, 54-68. doi: 10.1093/clipsy.9.1.54.

Ross, S. (2010). Ten-Year Fibromyalgia and CFS Pain Gone. EFT Universe. EFT Universe. Retrieved from <http://www.eftuniverse.com/serious-illnesses/ten-year-fibromyalgia-and-cfs-back-pain-gone>

Rotherham, M., Maynard, I., Thomas, O., Bawden, M., & Francis, L. (2012). Preliminary evidence for the treatment of type I “yips”: The efficacy of the emotional freedom techniques. *Sports Psychologist*, 26, 551-570.

Rowe, J. E. (2005). The effects of EFT on long-term psychological symptoms. *Counseling and Clinical Psychology*, 2(3), 104-111.

Ryle, G. (1949). *The Concept of Mind*. New York, NY: Barnes and Noble.

Salas, M. M., Brooks, A. J., & Rowe, J. E. (2011). The immediate effect of a brief energy psychology intervention (Emotional Freedom Techniques) on specific phobias: A pilot study. *Explore: The Journal of Science and Healing*, 7(3), 255–260.

Saltzman, A. (1991). *Downshifting: Reinventing Success on a Slower Track*. New York, NY: Harper Collins Publishers.

Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16(2), 1–8.

Scammell, S. (2002). Illness as Transformative Gift in People with Fibromyalgia. *International Journal of Healing & Caring*, 2(3), 1-20. Retrieved from <http://www.ijhc.org/wp-content/uploads/2016/03/Scammell-2-3.pdf>

Scharloo, M., Kaptein, A., Weinman J, Hazes, J. M., Willems, L. N., Bergman, W., & Rooijmans H. G. (1998). Illness perceptions, coping and functioning in patients with rheumatoid arthritis,

chronic obstructive pulmonary disease and psoriasis. *Journal of Psychosomatic Research*, 44(5), 573–585.

Schnurr, P. P., & Green, B. L. (2004). Understanding Relationships Among Trauma, Post-Traumatic Stress Disorder, and Health Outcomes. *Advances in Mind-Body Medicine*, 20(1), 18-29. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/15068106>

Schoen, C., Osborn, R., How, S. K., Doty, M. M., & Peugh, J. (2008). In chronic condition: experiences of patients with complex health care needs, in eight countries, 2008. *Health Affairs*, 28(1), w1-16. doi: 10.1377/hlthaff.28.1.w1.

Schwandt, T. A. (2007). *The SAGE Dictionary of Qualitative Inquiry*. Thousand Oaks: SAGE Publications Ltd.

Seamark, D. A., Blake, S. D., Seamark, C. J., & Haplin, D. (2004). Living with severe chronic obstructive pulmonary disease (COPD): perceptions of patients and their carers. An interpretative phenomenological analysis. *Palliative Medicine*, 18(7), 619-25. doi: 10.1191/0269216304pm928oa.

Sebastian, B., & Nelms, J. (2016). Emotional Freedom Techniques (EFT) for posttraumatic stress disorder: a systematic review and meta-analysis. *Explore: The Journal of Science and Healing*, 13(1), 16–25.

Sezgin, N., & Ozcan, B. (2009). The effect of progressive muscular relaxation and Emotional Freedom Techniques on test anxiety in high school students: A randomized controlled trial. *Energy Psychology: Theory, Research, and Treatment*, 1(1), 23-30.



- Seyle, H. (1976). *Stress in Health and Disease*. Boston, MA: Butterworth Publishers.
- Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology*, 7(3), 233- 243.
- Simmons, R. (2009). *The Curse of the Good Girl: Raising Authentic Girls with Courage and Confidence*. New York, NY: The Penguin Press.
- Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., ... Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13(1), 12–20. doi: 10.1002/wps.20084.
- Smith, J. (2010). Interpretative phenomenological analysis: a reply to Amedeo Giorgi. *Existential Analysis*, 21(2), 186–192. Retrieved from <http://psycnet.apa.org/psycinfo/2010-15570-001>
- Smith, J., & Eatough, V. (2007). Interpretative Phenomenological Analysis. In Lyons, E., & Coyle, A. (Eds.), *Analysing Qualitative Data in Psychology* (pp. 35-51). London: SAGE Publications Ltd.
- Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: SAGE Publications Ltd.
- Smith, J., Jarman, M., & Osborn, M. (1999). Doing Interpretative Phenomenological Analysis. In Murray, M., & Chamberlain, K. (Eds.), *Qualitative Health Psychology: Theories and Methods* (pp. 218-240). London: SAGE Publications Ltd.

Smith, J., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In Smith, J. (Ed), *Qualitative Psychology: A Practical Guide to Research Methods* (2<sup>nd</sup> edition) (pp. 53-80). London: SAGE Publications Ltd.

Smythe, E. (2011). From beginning to end: How to do hermeneutic interpretative phenomenology. In Thomson, G., Dykes, F., & Downe, S. (Eds.), *Qualitative Research in Midwifery and Childbirth*, New York, NY: Routledge.

Soltani, F., Jawan, J., & Ahmad, Z. (2014). Constructivism, Christian Reus-Smit and the Moral Purpose of the State. *Asian Social Science*, 10(10), 153-158.

Sperry, L. (2006). *Psychological Treatment of Chronic Illness: The Biopsychosocial Therapy Approach*. Washington, D.C.: American Psychological Association.

Stanton, A., Revenson, T., & Tennen, H. (2007). Health Psychology: Psychological Adjustment to Chronic Disease. *Annual Review of Psychology*, 58, 565-592. doi: 10.1146/annurev.psych.58.110405.085615.

Stapleton, P., Bannatyne, A. J., Urzi, K. C., Porter, B., & Sheldon, T. (2016). Food for Thought: A Randomised Controlled Trial of Emotional Freedom Techniques and Cognitive Behavioural Therapy in the Treatment of Food Cravings. *Applied Psychology: Health and Well Being*, 8(2), 232-257. doi: 10.1111/aphw.12070.

Stapleton, P., Church, D., Sheldon, T., Porter, B., & Carlopio, C. (2013). Depression symptoms Improve after successful weight loss with emotional freedom techniques. *ISRN Psychiatry*, 2013(2013), 1-7. doi: 10.1155/2013/573532.

Stapleton, P., Chatwin, H., William, M., Hutton, A., Pain, A., Porter, B., & Sheldon, T. (2016).

Emotional freedom techniques in the treatment of unhealthy eating behaviors and related psychological constructs in adolescents: A randomized controlled pilot trial. *Explore: The Journal of Science & Healing*, 12 (2), 113-122

Stapleton, P., Devine, S., Chatwin, H., Porter, B., & Sheldon, T. (2014). A feasibility study: emotional freedom techniques for depression in Australian adults. *Current Research in Psychology*, 5(1), 19-33. doi: 10.3844/crsp.2014.19.33.

Stapleton, P., Sheldon, T., & Porter, B. (2012a). Clinical Benefits of Emotional Freedom Techniques on Food Cravings at 12-Months Follow-up: A Randomised Controlled Trial. *Energy Psychology*, 4(1), 1-12.

Stapleton, P., Sheldon, T., & Porter, B. (2012b). Practical Application of Emotional Freedom Techniques for Food Cravings. *The International Journal of Healing and Caring*, 12(3), 1-8.

Stapleton, P., Sheldon, T., Porter, B., & Whitty, J. A (2011). Randomised Clinical Trial of a Meridian-Based Intervention for Food Cravings with Six-month Follow-up. *Behaviour Change*, 28(1), 1-16. doi: 10.1375/bech.28.1.1.

Starfield, B. (2011). Is Patient-Centered Care the Same As Person-Focused Care? *The Permanente Journal*, 15(2), 63–69. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140752/>

Stein, P., & Brooks, A. J. (2011). Efficacy of EFT (emotional freedom techniques) provided by coaches vs. licensed therapists in veterans with PTSD. *Energy Psychology: Theory, Research, & Treatment*, 3(1), 11-18.

Stewart, M. (2001). Towards a global definition of patient centred care – the patient should be the judge of patient centred care. *British Medical Journal*, 322(7248), 444–445.

Strasser, R. (2003). Rural health around the world: challenges and solutions. *Family Practice*, 20(4), 457–463.

Storey, L. (2007). Doing Interpretative Phenomenological Analysis. In Lyons, E., & Coyle, A. (Eds.), *Analysing Qualitative Data in Psychology* (pp. 51-65). London: SAGE Publications Ltd.

Swingle, P. (2010). Emotional Freedom Techniques (EFT) as an effective adjunctive treatment in the neurotherapeutic treatment of seizure disorders. *Energy Psychology: Theory, Research, and Treatment*, 2(1), 29-38. doi: 10.9769/EPJ.2010.2.1.PGS.

Swingle, P., Pulos, L., & Swingle, M. K. (2005). Neurophysiological Indicators of EFT Treatment of Post-Traumatic Stress. *Journal of Subtle Energies & Energy Medicine*, 15, 75-86

Taylor, S. (1983). Adjustment to Threatening Events: A Theory of Cognitive Adaptation. *American Psychologist*, 38(11), 1161-1173. doi: 10.1037/0003-066X.38.11.1161.

Taylor, S. E., Kemeny, M. E., Reed, G. M., Bower, J. E., & Gruenewald, T. L. (2000). Psychological resources, positive illusions, and health. *The American Psychologist*, 55(1), 99–109.

Temple, G.P., & Mollon, P. (2011). Reducing anxiety in dental patients using Emotional Freedom Techniques (EFT): A pilot study. *Energy Psychology: Theory, Research, and Treatment*, 3(2), 53-56. doi: 10.9769/EPJ.2011.3.2.GPT.

The Association for the Advancement of Meridian Energy Techniques (AAMET). (2017). *The AAMET Free EFT Manual: A Comprehensive Introductory Guide to EFT (Emotional Freedom Techniques) Update Version 2.8*. Retrieved from [https://aametinternational.org/wp-content/uploads/AAMET\\_Free\\_EFT\\_Manual.pdf](https://aametinternational.org/wp-content/uploads/AAMET_Free_EFT_Manual.pdf)

Thompson, P. W. (2000). Radical constructivism: Reflections and directions. In Steffe, L. P., & Thompson, P. W. (Eds.), *Radical constructivism in action: Building on the pioneering work of Ernst von Glasersfeld* (pp. 412-448). London: Falmer Press.

Thorne, S., Paterson, B., & Russell, C. (2003). The Structure of Everyday Self-Care Decision Making in Chronic Illness. *Qualitative Health Research*, 13(10), 1337-1352. doi: 10.1177/1049732303258039.

Todorova, I. (2011). Explorations with interpretative phenomenological analysis in different socio-cultural contexts. *Health Psychology Review*, 5(1), 34-38.

Toombs, S. (1988). Illness and the paradigm of lived body. *Theoretical Medicine and Bioethics*, 9(2), 201-226. doi: 10.1007/BF00489413.

Ventegodt, S., Thegler, S., Andreasen, T., Struve, F., Enevoldsen, L., Bassaine, L., ... Merrick, J. (2007). Clinical Holistic Medicine (Mindful, Short-Term Psychodynamic Psychotherapy

Complemented with Bodywork) in the Treatment of Experienced Physical Illness and Chronic Pain. *The Scientific World Journal*, 7, 310-317. doi: 10.1100/tsw.2007.68.

Von Glasersfeld, E. (1984). An introduction to radical constructivism. In Watzlawick, P. (Ed.), *The Invented Reality* (pp.17-40). New York: W.W. Norton & Company.

Von Glasersfeld, E. (1989). Constructivism in education. In Husen, T., & Postlewaite, N. (Eds.), *International Encyclopedia of Education [Suppl.]* (pp.162-163). Oxford, England: Pergamon Press.

Von Glasersfeld, E. (1995). A constructivist approach to teaching. In Steffe, L., & Gale, J. (Eds.), *Constructivism in education* (pp. 3-16). New Jersey: Lawrence Erlbaum Associates, Inc.

Walker, C. (2010). Ruptured Identities: Leaving work because of chronic illness. *International Journal of Health Services*, 40(4), 629-643. doi: 10.2190/HS.40.4.d.

Ware, C. (1993). Society, Mind and body in chronic fatigue syndrome: an anthropological view. In Bock, G., & Whelan, J. (Eds.), *Chronic Fatigue Syndrome* (pp. 62-73). Chichester, West Sussex: John Wiley & Sons Ltd.

Webb, L. (2012). The recovery model and complex health needs: What health psychology can learn from mental health and substance misuse service provision. *Journal of Health Psychology*, 17(5), 731-741.

Wells, S., Polglase, K., Andrews, H., Carrington, P., & Baker, A. H. (2003). Evaluation of Meridian-Based Intervention, EFT for Reducing Specific Phobias of Small Animals. *Journal of Clinical Psychology*, 59(9), 943-966.

Werner, A., Steihaug, S., & Malterud, K. (2003). Encountering the Continuing Challenges for Women with Chronic Pain: Recovery through Recognition. *Qualitative Health Research*, 13(4), 491-509.

Whitfield, G., & Williams, C. (2003). The evidence base for cognitive-behavioural therapy in depression: delivery in busy clinical settings. *Advances in Psychiatric Treatment*, 9(1), 21-30. doi: 10.1192/apt.9.1.21.

Whitley, R., & Drake, R. (2010). Recovery: A Dimensional Approach. *Psychiatric Services*, 61(12), 1248-1250. doi: 10.1176/ps.2010.61.12.1248

Wilberg, P. (2011). From Existential Psychotherapy to Existential Medicine. *Existential Analysis*, 22(2), 303-317.

Wiles, R., Cott, C., & Gibson, B. (2008). Hope, expectations and recovery from illness: a narrative synthesis of qualitative research. *Journal of Advanced Nursing*, 64(6), 564 – 573.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in theory and method*. Philadelphia: Open University Press.

Winzelberg, A., Classen, C., Alpers, G. W., Roberts, H., Koopman, C., Adams, R. E., ... Taylor, C. B. (2003). Evaluation of an internet support group for women with primary breast cancer. *Cancer*, 97(5), 1164-1173.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press

World Health Organization (WHO). (2016). *The determinants of health*. Retrieved from <http://www.who.int/hia/evidence/doh/en/>

Wonderlich, S. A., Crosby, R. D., Mitchell J. E., Thompson, K. M., Redlin, J., Demuth, G., ... Haseltine, B. (2001). Eating disturbance and sexual trauma in childhood and adulthood. *International Journal of Eating Disorders*, 30(4), 401-412. doi: 10.1002/eat.1101.

Young, R., & Collin, A. (2004). Introduction: Constructivism and social constructionism in the career field. *Journal of Vocational Behaviour*, 64(3), 373–388. doi: 10.1016/j.jvb.2003.12.005.

Young, J., Klosko, J., & Weishaar, M. (2003). *Schema Therapy: A Practitioner's Guide*. New York, NY: Guilford Press.

Yow, V. (2005). *Recording Oral History: A Guide for the Humanities and Social Sciences* (2nd edition). Lanham: Altamira Press.



# Appendices

---

## Appendix A: Overview of EFT literature investigating use of EFT for physical health conditions

**Table A1: Summary of EFT literature investigating the use of EFT for physical health conditions**

Health Condition	Reference	Study Configuration	Overview of Findings
<b>Psoriasis</b>	Hodge & Jurgens (2009)	<ul style="list-style-type: none"> <li>- 12 psoriasis patients (4 men, 8 women) taught EFT in a 6-hour workshop and instructed to use EFT daily</li> <li>- Outcome measures: Skindex-29 and SA-45 questionnaires at pre-intervention, post-intervention, one month and three month follow-ups</li> <li>- Explored the link between stress and psoriasis and potential quality of life benefits of EFT for psoriasis patients were investigated</li> </ul>	<ul style="list-style-type: none"> <li>- Mean subscales of SA-45, namely Global Severity Index (GSI) and Positive Symptom Total (PST) decreased by 50.67% and 41.79% at post-intervention respectively</li> <li>- Skindex-29 scores indicated statistically significant improvements in emotional distress, symptoms and functioning at post-intervention and follow-up</li> <li>- Pre-treatment qualitative data reported by patients indicated that majority of them perceived stressful events to have caused outbreak of psoriasis or worsening of symptoms</li> <li>- The treatment sessions identified themes of core beliefs in participants that they were “not good enough” and/or “not loveable”</li> <li>- At post-treatment, participants reported feeling more “relaxed”, reduced or no flare-ups, reduced itching, improved interpersonal relationships and feeling less concerned/embarrassed/bitter about their skin condition</li> <li>- Pre-intervention, five out of the twelve participants who scored in the clinical distress range for anxiety in the SA-45 questionnaire no longer met the clinical criteria for anxiety at post-intervention, with benefits maintained for four at three-month follow-up</li> <li>- EFT might be advantageous in reducing psychological stress associated with living with a chronic illness, symptom management, improvement of relationships and overall daily quality of life</li> </ul>
<b>Chronic Pain</b>	Ortner, Palmer-Hoffman & Clond (2014)	<ul style="list-style-type: none"> <li>- Fifty adults suffering from chronic pain participated in a three day EFT workshop</li> </ul>	<ul style="list-style-type: none"> <li>- Significant reduction reported on the PCS total score (-43%, <math>p &lt; .001</math>), and the individual item scores for rumination, magnification, and helplessness</li> </ul>

Health Condition	Reference	Study Configuration	Overview of Findings
		<ul style="list-style-type: none"> <li>- Outcome measures: Pain Catastrophizing Scale (PCS) and the Multidimensional Pain Inventory (MPI) right before and after treatment. Follow ups were conducted at one month and six months</li> </ul>	<ul style="list-style-type: none"> <li>- Significant improvement reported on the MPI items of pain severity, interference, life control, affective distress, and dysfunctional composite</li> <li>- Reductions in pain severity not maintained in the long term</li> <li>- At six month follow up, improvement was maintained on the PCS (-42%, <math>p &lt; .001</math>), and on the life control aspect of the MPI. Participants, reported feeling a greater sense of control and improved coping ability</li> <li>- EFT may help with immediate alleviation of pain severity, and improve people's ability to cope with their pain</li> </ul>
<b>Pain</b>	Church & Brooks (2010)	<ul style="list-style-type: none"> <li>- 216 healthcare professionals assessed for psychological distress symptoms including self-rated pain, emotional distress, cravings and pain</li> <li>- Outcome measures: SA-45, self-rated pain, cravings and emotional distress. Measured before, after 2-hours of self-applied EFT and at 90-day follow-up</li> </ul>	<ul style="list-style-type: none"> <li>- Significant reduction in all SA-45 subscales and ratings of pain, emotional distress and cravings at post-intervention (<math>p &lt; 0.001</math>); Gains maintained at follow-up</li> <li>- Severity and breadth of psychological symptoms reduced by 45% and 40% respectively (<math>p &lt; 0.001</math>)</li> <li>- At follow-up, benefits were maintained for symptom severity (<math>p &lt; .034</math>, <math>r = .199</math>), but not for breadth of symptoms (<math>p &lt; .0117</math>, <math>r = .148</math>)</li> <li>- EFT may provide immediate effects on psychological distress, pain, and cravings</li> </ul>
<b>Tension Type Headache (TTH)</b>	Bougea, Spandideas, Alexopoulos, Thomaidis, Chrousos & Darviri (2013)	<ul style="list-style-type: none"> <li>- 35 outpatients meeting criteria for frequent TTH as per as per the International Headache Society guidelines randomised to an EFT intervention group or a standard care control</li> <li>- Outcome measures: Perceived Stress Scale (PSS), the Multidimensional Health Locus of Control Scale (MHLC), Short-Form questionnaire-36 (SF-36)</li> </ul>	<ul style="list-style-type: none"> <li>- Statistically significant improvements in the frequency (episodes/month) and intensity of headaches (scale of 0 – 10) after application of the technique</li> <li>- Significant benefits improved in the SF-36 quality of life questionnaire sub-scales at post-intervention, particularly in physical functioning (<math>P = 0.005</math>), role limitations due to physical health (<math>P = 0.001</math>), role limitations due to emotional problems (<math>P = 0.008</math>), energy/fatigue (<math>P &lt; 0.001</math>), emotional well-being (<math>P &lt; 0.001</math>), pain (<math>P &lt; 0.001</math>) and general health (<math>P = 0.002</math>), except for social functioning (<math>P = 0.082</math>)</li> </ul>

Health Condition	Reference	Study Configuration	Overview of Findings
		<ul style="list-style-type: none"> <li>- Salivary cortisol levels, as well as the frequency and intensity of headache episodes also measured</li> <li>- Participants in the EFT group instructed to use EFT twice a day</li> <li>- Data collected at pre-intervention, at the end of each week of the 8-week study period, and at one month follow-up at the end of 8 weeks</li> </ul>	<ul style="list-style-type: none"> <li>- No significant improvements were found in the post-intervention cortisol morning and evening levels (<math>P = 0.468</math> and <math>P = 0.824</math>, respectively), suggesting no effect of EFT treatment on the stress hormone</li> <li>- MHLC questionnaire responses at post-intervention indicated that patients believed to have greater influence and ability to take more responsibility for their own health (<math>P &lt; 0.001</math>)</li> <li>- Improvements in sleep quality and satisfaction were also reported in the treatment group</li> </ul>
<b>Frozen Shoulder</b>	Church & Nelms (2016)	<p>37 people with frozen shoulder, having limited range of motion, and pain were randomised into a wait-list control group, EFT treatment group, and a cognitive exposure coupled with diaphragmatic breathing (DB) treatment group. Both treatment groups were given half hour EFT/DB sessions. Follow-up was conducted after 30 days.</p> <p>Outcome measures: SA-45 for psychological symptoms, Likert Scale for pain, range of motion using a goniometer. Measures were assessed at baseline, post-intervention, and 30-day follow-up.</p>	<ul style="list-style-type: none"> <li>- Psychological symptoms significantly improved at post-intervention compared to baseline for the EFT group for all the SA-45 subscales apart from phobic anxiety, psychoticism, and paranoia. Gains were maintained at follow-up (<math>p &lt; .001</math>).</li> <li>- Large treatment effects were found for EFT for anxiety and pain (<math>d = 0.9</math>) and depression (<math>d = 1.1</math>).</li> <li>- Psychological symptoms significantly improved at post-intervention compared to baseline for the DB group for all the SA-45 subscales apart from hostility, psychoticism, depression and phobic anxiety. Gains were not maintained at follow-up.</li> <li>- Range of motion improved at post-intervention and benefits were maintained at follow-up for two of the five motion dimensions in the EFT group. The remaining dimensions showed clinical improvements, however, they were not statistically significant.</li> <li>- Significant decrease in pain was observed in both the EFT and DB treatment groups. Mean pain score at post-intervention had reduced from 4 to 2 in the EFT group. This improvement was maintained on follow-up. In the DB group, pain reduced from 4 to 3, and stayed at 3 on follow-up.</li> <li>- Non-significant change in pain was observed in the waitlist control group.</li> </ul>

Health Condition	Reference	Study Configuration	Overview of Findings
			<ul style="list-style-type: none"> <li>- EFT produces psychological improvements which has immediate benefits for physical symptoms. Psychological improvements in conditions like depression and anxiety are maintained long-term.</li> <li>- Brief EFT treatment can also be useful in decreasing pain.</li> <li>- Stimulation of acupoints is an active ingredient of the EFT process.</li> </ul>
<b>Traumatic Brain Injury</b>	Church & Palmer-Hoffman (2014)	<ul style="list-style-type: none"> <li>- 59 veterans with PTSD symptoms in clinical range were randomised to standard of care/wait list group and EFT treatment group</li> <li>- EFT group administered six hour-long EFT sessions</li> <li>- Outcome measures: Somatoform symptoms measured using the Patient Health Questionnaire somatoform module of the Primary Care Evaluation of Mental Disorders (PRIME-MD), and self-reported TBI symptoms</li> <li>- Data measured at pre-test, after three and six sessions. Follow-ups were conducted at three and six months.</li> <li>- Symptoms measured included pain, digestion, shortness of breath, seizures, high blood pressure, and loss of vision among others.</li> </ul>	<ul style="list-style-type: none"> <li>- At post-intervention, EFT group had fewer symptoms than the standard of care/wait list group</li> <li>- EFT group showed reduction in symptoms at post-intervention. After three sessions, statistically significant reductions in TBI symptoms were observed in the EFT group (41%, <math>p &lt; 0.0021</math>)</li> <li>- The wait list group did not show any changes</li> <li>- Symptom improvements were maintained at three-month and six-month follow-ups in the EFT group (<math>p &lt; 0.0006</math>)</li> <li>- EFT offers potential to offer at least partial rehabilitation of TBI with the possibility of long-term clinical improvements</li> </ul>

Health Condition	Reference	Study Configuration	Overview of Findings
<b>Traumatic Brain Injury</b>	Craig, Bach, Grosbeck & Benor (2009)	<ul style="list-style-type: none"> <li>- Single patient case study examining woman with TBI, contracted following a motor vehicle accident six years earlier</li> <li>- Patient had suffered multiple fractures, and a left frontal subdural hematoma in the accident</li> <li>- Reported symptoms prior to treatment: anxiety, panic attacks, vertigo, balance difficulties, cognitive problems, and need of a walking cane</li> </ul> <p>Outcome measures: EEG before and after treatment, self-reported symptoms. One-year follow-up</p>	<ul style="list-style-type: none"> <li>- EEG taken prior to EFT treatment showed a significant amplitude of beta waves (24 – 38 Hz), indicating presence of anxiety. During the session, EEG also pointed to a pattern of relaxation. At the end of the treatment, the amplitude of high frequency beta waves had reduced (4 – 13 Hz).</li> <li>- Reduction of symptoms reported at post-intervention. Improvements in cognitive ability, physiological functioning and ability to walk without support maintained at one-year follow-up.</li> </ul>
<b>Fibromyalgia</b>	Brattberg (2008)	<ul style="list-style-type: none"> <li>- 86 women with fibromyalgia randomised to an EFT treatment group, or a waitlist control group</li> <li>- EFT treatment group taught to use EFT over the internet and asked to self-administer it once daily for eight weeks</li> <li>- Outcome measures: Pain (Pain Catastrophizing Scale/PCS, Chronic Pain Acceptance Questionnaire/CPAQ), anxiety and depression (Hospital Anxiety and Depression Scale), overall quality of life (SF-36), self-efficacy (General Self-efficacy Scale), and Subjective Units of</li> </ul>	<ul style="list-style-type: none"> <li>- Self-reported pain SUD score decreased in the EFT group from 7 to 5. No decrease was reported by the waitlist group</li> <li>- Reduction in stress and tension observed in the EFT group at post-intervention (<math>p = 0.02</math>)</li> <li>- Statistically significant improvements were observed in the EFT group for almost all HAD and SF-36 measures of health.</li> <li>- The EFT group also showed significant improvements in ability to live with pain as measured via PCS and CPAQ.</li> </ul> <p>EFT group also reported increased activity group compared to the waitlist group. Benefits in self-efficacy was reported in the EFT group compared to the waitlist group, however the difference was not statistically significant</p>

Health Condition	Reference	Study Configuration	Overview of Findings
		<p>Distress (SUD) for experienced pain, the influence of pain and stress</p> <p>- Outcomes were measured at pre and post intervention</p>	<p>- EFT has potential as an accessible treatment method, which can be self-administered and also taught via the internet.</p>
<b>Respiratory Disorders</b>	Babamahmoodi, Arefnasab, Noorbala, ... & Darabi (2015)	<p>- 28 male veterans randomised to EFT treatment group, or waitlist group.</p> <p>- Veterans had undergone pulmonary injury by mustard gas during war, and had mild to moderate pulmonary problems as per the Global Initiative for Chronic Obstructive Lung Disease (GOLD) criteria</p> <p>- EFT group provided eight weekly 90 minute group EFT sessions, and asked to practice EFT twice daily.</p> <p>- Outcome measures: General Health Questionnaire, GHQ-28 (encompassing somatic symptoms, anxiety/insomnia, social dysfunction and depression), Saint George Respiratory Questionnaire, SGRQ (encompassing frequency and severity of respiratory symptoms, activities limited by breathlessness, psychological and social functioning impacts of pulmonary disease), and two immunological tests namely Lymphocyte Transformation Test (LTT) and The enzyme-linked Immunosorbent</p>	<p>- At post-intervention, EFT treatment group showed improvements in mental health (<math>F=79.24</math>, <math>p=0</math>) and health-related quality of life (<math>F=13.89</math>, <math>p=0.001</math>).</p> <p>- Improvements in somatic symptoms (<math>F = 5.81</math>, <math>p=0.02</math>), and anxiety/insomnia (<math>F=24.03</math>, <math>p&lt;0.001</math>) were also observed.</p> <p>- Social dysfunction (<math>F=21.59</math>, <math>p&lt;0.001</math>), frequency and severity of respiratory symptoms (<math>F=20.38</math>, <math>p&lt;0.001</math>) improved in the EFT treatment at post-intervention</p> <p>- Immunological function improved in the EFT treatment, as measured using LTT and ELISA</p> <p>- EFT offers potential as a therapeutic approach for improving psychological and immunological outcomes in people with pulmonary conditions.</p>

Health Condition	Reference	Study Configuration	Overview of Findings
		<p>Assay (ELISA).</p> <p>- Outcomes were measured at baseline and post-intervention after 8-weeks.</p>	
<b>Cancer</b>	Baker & Hoffman (2014)	<p>- 41 women with breast cancer were provided a three-week EFT course, and later asked to self-administer EFT for the following nine weeks as required.</p> <p>- Outcome measures: Profile of Mood States (POMS), Brief Pain Inventory (BPI), Functional Assessment of Cancer Therapy-Endocrine Symptom subscale (FACT-ES), Hunter's Hot Flush Rating Scale (HFRS). Ratings completed at baseline, 6-weeks, and 12-weeks.</p> <p>- Investigated effects of EFT for adverse side-effects experienced by women undergoing hormonal treatment for breast cancer.</p>	<p>- Significant improvements in all subscales of POMS, except anger at both 6-weeks and 12-weeks.</p> <p>- Significant benefits reported in Total Mood Disturbance (<math>p = 0.005</math>; <math>p = 0.008</math>), anxiety (<math>p = 0.003</math>; <math>p = 0.028</math>), depression (<math>p = 0.006</math>; <math>p = 0.020</math>) and fatigue (<math>p = 0.008</math>; <math>p = 0.033</math>) at both 6-weeks and 12-weeks.</p> <p>- Mean pain interference score increased at 6-weeks but decreased at 12-weeks compared to baseline</p> <p>- Mean fatigue interference score decreased at 6-weeks compared to baseline. Benefits were maintained at 12-weeks.</p> <p>- Mean problem rating score for hot flushes and night sweats decreased at 6-weeks, and benefits were maintained at 12-weeks.</p> <p>- EFT may serve as a useful self-help tool for women undergoing hormonal therapy for cancer treatment and experiencing associated side-effects.</p>
<b>Diabetes</b>	Hajloo, Ahadi, Rezabakhsh & Mojembari (2014)	<p>- 30 patients with Type 2 Diabetes on insulin treatment were randomised to EFT treatment group and control group</p> <p>- EFT treatment group was given 12 EFT sessions</p> <p>- Outcome measures: HbA1C blood levels were measured at baseline, and at post-intervention.</p>	<p>- HbA1C levels decreased at post-intervention for the EFT treatment group</p> <p>- EFT was found to be effective in controlling blood glucose levels in diabetic patients.</p>



Health Condition	Reference	Study Configuration	Overview of Findings
<b>Diabetes</b>	Alwan & Nawajah (2013)	<ul style="list-style-type: none"> <li>- 36 adults with diabetes divided into an EFT treatment group and control group.</li> <li>- Treatment group was administered four EFT treatment sessions</li> <li>- Outcome measures: Happiness Scale measured at baseline, and post-intervention</li> <li>- Exploring the effects of EFT treatment on the happiness level of diabetics</li> </ul>	<ul style="list-style-type: none"> <li>- EFT treatment group showed statistically significant (<math>p = 0.000</math>) differences in happiness levels as compared to the treatment group.</li> <li>- EFT treatment group showed a statistically significant (<math>p = 0.000</math>) improvement in happiness levels at post-intervention compared to the baseline levels.</li> <li>- At post-intervention, the EFT treatment group showed large effect sizes in all three sub-scales of the Happiness Scale, tranquillity (<math>EZ = 0.879</math>), moderation (<math>EZ = 0.879</math>), and love (<math>EZ = 0.878</math>).</li> <li>- EFT may be useful in improving happiness levels in people with diabetes.</li> </ul>

## Appendix B: Ethics Clearance Certificate

### Human Ethics Certificate of Approval

This is to certify that the project below was considered by the Monash University Human Research Ethics Committee. The Committee was satisfied that the proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research* and has granted approval.

**Project Number:** CF14/3800 - 2014001991

**Project Title:** Against all odds: Cases of Radical Recovery through Emotional Freedom Techniques (EFT)

**Chief Investigator:** Dr Margaret Simmons

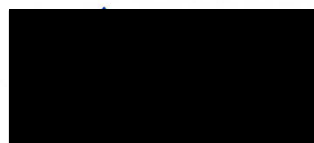
**Approved:** **From:** 13 January 2015

**To:** 13 January 2020

---

**Terms of approval - Failure to comply with the terms below is in breach of your approval and the Australian Code for the Responsible Conduct of Research.**

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, before any data collection can occur at the specified organisation.
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must include your project number.
6. **Amendments to the approved project (including changes in personnel):** Require the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.



Professor Nip Thomson  
Chair, MUHREC

cc: Ms Mahima Kalla, Dr Anske Robinson, Assoc Prof Peta Stapleton