



Original article

# Emotional Freedom Techniques (EFT) to reduce the side effects associated with tamoxifen and aromatase inhibitor use in women with breast cancer: A service evaluation

Barbara S. Baker\*, Caroline J. Hoffman

*The Haven, Effie Road, London SW6 1TB, UK*

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## Abstract

**Introduction:** Adverse effects associated with tamoxifen and aromatase inhibitor use are the most common reason reported by women with breast cancer for discontinuing hormonal therapies. Poor compliance is associated with an increased risk of mortality and early recurrence. The primary aim of this study was to evaluate Emotional Freedom Techniques (EFT) for improving mood state, and secondarily, menopausal symptoms, fatigue, and pain experienced by women with breast cancer receiving hormonal therapies.

**Methods:** Participants ( $n=41$ ) received a three-week course of EFT, consisting of one session of three hours per week, followed by use of the self-tool over the next nine weeks as required. Self-report questionnaires were used to assess mood, pain, fatigue, endocrine (menopausal) symptoms and hot flushes and night sweats, together with a hot flush diary, at baseline and at 6 and 12 weeks. Participants also completed 7-day home practice sheets for the first six weeks, a feedback form at six weeks and were invited to attend a follow-up focus group at eight weeks.

**Results:** Statistically significant improvements in Total Mood Disturbance ( $p=0.005$ ;  $p=0.008$ ), and anxiety ( $p=0.003$ ;  $p=0.028$ ), depression ( $p=0.006$ ;  $p=0.020$ ) and fatigue ( $p=0.008$ ;  $p=0.033$ ) occurred at both 6 and 12 weeks, respectively, compared to baseline. In addition, mean fatigue interference and global scores, numbers of hot flushes and the hot flush problem rating score decreased at 6 and/or 12 weeks.

**Discussion/conclusions:** These preliminary findings suggest that EFT may be an effective self-help tool for women with breast cancer experiencing side effects from hormonal therapies.

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**Keywords:** Breast cancer; Emotional Freedom Techniques; Adjuvant hormonal therapies; Side effects

## Introduction

Substantially reduced rates of recurrence and mortality have been shown in post-menopausal women with oestrogen receptor-positive breast cancer treated for five years with tamoxifen or aromatase inhibitors [1,2]. In addition, continuation of tamoxifen use for up to ten years resulted in a further reduction in recurrence, and approximately halved breast cancer mortality during the second decade after diagnosis [3]. However, despite their well-documented efficacy, poor patient

adherence/compliance and discontinuation rates of 45–96% and 12–73%, respectively, have been reported in various studies [4]. Furthermore, poor compliance and lack of persistence has been shown to be associated with an increased risk of mortality and early recurrence in these women [5–7]. The most common reason reported by women with breast cancer for discontinuing hormonal therapies is the adverse effects frequently associated with their use [8,9]. The adverse effects most frequently cited are hot flushes, fatigue, joint pains, and insomnia [10–13].

Clearly there is a need for suitable therapeutic strategies to manage the troublesome side effects associated with tamoxifen and aromatase inhibitor use, which would in turn help to encourage continued treatment with its attendant survival advantages. Complementary therapies such as acupuncture, cognitive behavioural therapy and herbal medicines have previously been used alongside conventional medical treatments to improve

*Abbreviation:* EFT, Emotional Freedom Techniques.

\* Corresponding author. Tel.: +44 020 7384 0044; fax: +44 020 7384 0001.

*E-mail addresses:* [barbara.baker@thehaven.org.uk](mailto:barbara.baker@thehaven.org.uk) (B.S. Baker), [caroline.hoffman@thehaven.org.uk](mailto:caroline.hoffman@thehaven.org.uk) (C.J. Hoffman).

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fatigue and joint pains, insomnia or hot flushes experienced by women with breast cancer [14–17]. Emotional Freedom Techniques (EFT) is a relatively new complementary treatment which has developed in the past 20 years from a novel intervention, derived from Thought Field Therapy, to an “evidence-based” practice which, it has been proposed, may meet the standards of the American Psychological Association Division 12 Task Force [18]. EFT is an easy to learn self-help tool which involves tapping specific acupuncture points whilst repeating aloud an affirmation that includes the problem to be addressed. It has been shown in several randomised controlled trials (regarded as the “gold standard” of research) to be an efficacious, or probably efficacious, treatment for a number of conditions including anxiety, depression, phobias and Post Traumatic Stress Disorder [19]. However, to date, EFT has not been studied as a treatment for emotional and/or physical symptoms experienced by cancer patients. Visitors to The Haven cancer support centres have anecdotally reported improvement in the impact of negative emotions such as fear, anxiety and in relief of physical symptoms such as hot flushes, pain and nausea associated with cancer treatment after practicing EFT. We therefore performed a service evaluation to test a self-EFT protocol for the management of side effects associated with hormonal therapy use in women with breast cancer.

## Patients & methods

### Study design

This was an internal service evaluation of women with breast cancer who attended the Haven centres in London and Leeds. Informed consent was given by the Visitors for their personal data to be held and processed (in accordance with the Data Protection Act) and for the collection of their feedback regarding treatment programmes they had received. As this was not a research project, it was not subject to research ethical approval.

### Participants

Women with a diagnosis of breast cancer who were currently taking hormonal treatments, including tamoxifen, and the Aromatase Inhibitors – anastrozole (Arimidex®), exemestane (Aromasin®) or letrozole (Femara®), and experiencing treatment-associated side effects, and who had registered as new Visitors to either the London or Leeds Haven centre from 1st January 2011 to 1st September 2012, were invited by email to take part in the service evaluation.

Participants had an average age of 54.6 years (range 38–68 years), 51.2% ( $n=21$ ) were married, 85.4% had received surgery (lumpectomy,  $n=18$ ; mastectomy,  $n=16$ ; quadrantectomy  $n=1$ ), 53.6% chemotherapy (adjuvant  $n=19$ ; neoadjuvant  $n=3$ ) and 73.2% ( $n=30$ ) radiotherapy. This was a representative sample of women with breast cancer and of those who attend the Haven for support. Just over one-third ( $n=15$ ; 36.6%) received a range of other complementary therapies during the follow-up

period after the three-week EFT course, the main therapies being acupuncture ( $n=5$ ), counselling ( $n=4$ ) and yoga ( $n=4$ ).

### EFT course protocol

EFT is an easy to learn self-help tool which involves tapping specific acupuncture points on the face, collarbone, under the arm and on the top of the head whilst repeating aloud an affirmation that includes the problem to be addressed. The EFT Short Cut method published by Craig [20] was used in this study, according to the Association for the Advancement of Meridian Energy Techniques training regulations. Tapping was used to address specific symptoms according to individual needs, including hot flushes, aches and pains and specific emotional states.

Participants took part in a 3-week course of EFT, consisting of one session of three hours per week. In the first week they were taught the EFT protocol and its application for mood and physical side effects. They were given the Haven at Home DVD [21], which includes a section illustrating the application of the tapping protocol, to aid home practice and a notebook containing a structured self-work outline, a diagram of the tapping points, and a self-measurement scale to complete. Progress was checked the second week, and fine-tuning according to individual needs was applied in the final week. Subsequently, participants were encouraged to go away for the following nine weeks and use the technique as and when they felt necessary.

### Outcomes measures

The primary outcome measure for the study was the Profile of Mood States (POMS).

POMS (65 items) is a measure of affective states comprising a Total Mood Disturbance Scale and six factor-based subscale scores [22,23]. Further self-report questionnaires were used to assess pain, fatigue, endocrine (menopausal) symptoms and hot flushes and night sweats: The short form of the Brief Pain Inventory questionnaire (BPI, 15 items) assesses pain severity and the impact of pain on daily functions [24], whilst the Brief Fatigue Inventory (BFI, 9-items) is used to rapidly assess fatigue severity and the impact of fatigue on daily functioning [25]. Menopausal symptoms were assessed using the Functional Assessment of Cancer Therapy-Endocrine Symptom subscale, version 4 (FACT-ES, 19 items) [26], and hot flushes/night sweats with Hunter’s Hot Flush Rating Scale (HFRS, 7-items) [27] which included both frequency and problem-rating subscales. All questionnaires were completed at baseline, and at 6 and 12 weeks.

These validated outcome measures have all been used previously in studies of patients with cancer, but not in previous studies of EFT [19].

Participants were also asked to complete a 7-day hot flush diary [28] at the same three time points, and were given 7-day home practice sheets, each week for the first six weeks, to complete. A feedback form at six weeks and follow-up focus group at eight weeks were used to obtain qualitative data on the participant’s experience of EFT.

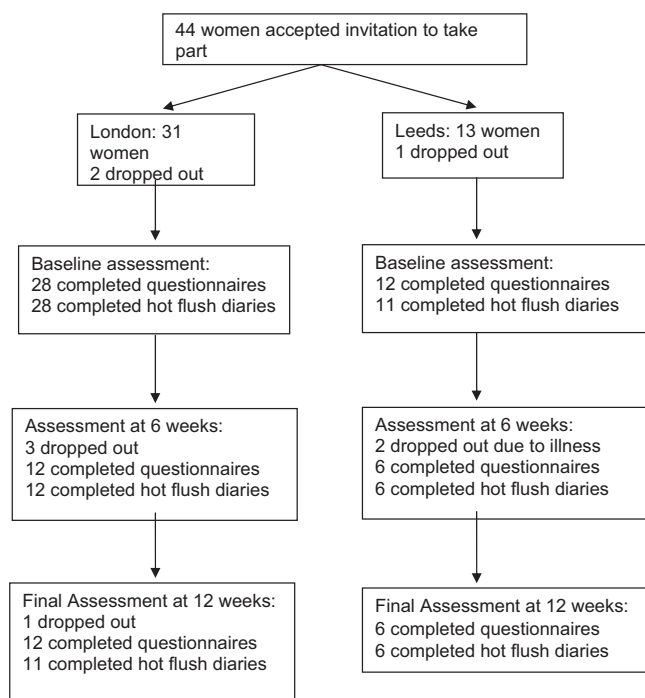


Fig. 1. Flow diagram of the EFT service evaluation.

The focus groups (one in each of the London and Leeds Haven centres) were facilitated by the EFT therapists and involved informal discussion about the study, which was recorded in note form.

### Data analysis

Descriptive statistical analysis (mean  $\pm$  SD) and the Wilcoxon signed rank test, using the statistics software package SPSS, were used to analyse the questionnaire scores of the study group before (T1) and at six weeks (T2) and 12 weeks (T3) after the intervention. In addition, all three time-points were compared using the Friedman test. These non-parametric statistical tests were used as not all the data was of a normal distribution. All tests had a cut-off value for statistical significance of  $p = 0.05$  (two-tailed). To account for missing items in the POMS and FACT-ES questionnaires, a prorated item score (also known as standard mean imputation) was calculated. This was done by multiplying the sum of the subscale items answered by the number of items in the subscale, and then dividing by the number of items answered to give the subscale score. This procedure is acceptable when more than 50% of the items were answered; where this was not the case the subscale score was not calculated for that sample.

Content analysis was used to analyse the qualitative data collected in the focus groups, and themes were identified.

### Results

Of the 44 women who accepted the invitation to take part, three dropped out before the start of the study leaving a total of 41 participants (29 in London, 12 in Leeds) (Fig. 1). All of the

participants except one completed the baseline questionnaires; two failed to complete the hot flush diaries. Six participants dropped out during the study, and 18 (50%) of the remainder completed the questionnaires at 6 and 12 weeks.

Reasons for drop-out during the study were feeling uncomfortable and that it wasn't for them ( $n = 3$ ) and too unwell to participate ( $n = 2$ ). In one case no reason was given.

Reasons for non-completion of questionnaires included being too busy ( $n = 3$ ), illness ( $n = 2$ ), didn't feel the need for support ( $n = 1$ ), was away ( $n = 1$ ), not able to contact ( $n = 1$ ), too long after the study ( $n = 1$ ) and worry about cause of pain/attending another complementary therapy course at the same time ( $n = 1$ ). Reasons for the lack of completion of questionnaires were not established in nine cases.

Demographic differences were noted between the group who completed all three questionnaires (completers,  $n = 15$ , one of which provided no demographic details) and the remaining participants who dropped out or didn't complete all three questionnaires (non-completers,  $n = 26$ ). The non-completers were moderately younger than the completers (52.6 vs 58.4 years) and only 42% were married, compared to 71% in the completers group. The majority in both groups had undergone surgery (lumpectomy or mastectomy) and received radiotherapy, but there was a higher frequency of chemotherapy use in the non-completers versus the completers (82% vs 44%).

### Hormonal therapies and side-effects

Nineteen (46%) of the participants were taking tamoxifen and 11 (27%) letrozole at the start of the EFT course. The remainder were receiving anastrozole ( $n = 7$ ), exemestane ( $n = 3$ ) and/or goserelin ( $n = 1$ ). At baseline, almost half of the participants ( $n = 19$ ) had received hormonal treatment for up to 10 months, nearly a quarter ( $n = 9$ ) for 11–20 months and the remainder ( $n = 11$ ) for 21–60 months.

Only approximately one-third of participants had taken a different hormonal therapy previously, and the type, and length of time taken varied between participants.

Hot flushes and fatigue were commonly experienced by women taking either tamoxifen or Aromatase Inhibitors (letrozole, anastrozole or exemestane) (Table 1). In contrast, aches and pains were more frequently associated with Aromatase Inhibitors, as previously reported [29]. Conversely, mood swings were more frequent amongst women taking tamoxifen.

### Outcomes

#### Profile of Mood States

There was a significant improvement in scores over the three time periods (T1, T2 and T3) for Total Mood Disturbance, and all the Profile of Mood States (POMS) subscales except for anger which remained unchanged (Table 2). Improvements in Total Mood Disturbance, and the anxiety, depression and fatigue subscale scores occurred at both T2 and T3 compared to T1.

Vigour significantly increased, and confusion significantly decreased at T2 compared to T1, but there were no significant

Table 1  
Comparison of tamoxifen and aromatase inhibitor-associated side-effects.

Symptom	Tamoxifen (n = 19) No. (%)	Aromatase inhibitors (n = 21) No. (%)
Hot flushes	<b>18 (19.1)<sup>b</sup></b>	<b>14 (15.7)</b>
Night sweats	12 (12.8)	10 (11.2)
Aches & pains	13 (13.8)	<b>17 (19.1)</b>
Fatigue	<b>15 (16.0)</b>	<b>19 (21.3)</b>
Nausea	2 (2.1)	7 (7.9)
Lowered sex drive	10 (10.6)	8 (9.0)
Vaginal dryness, discharge	11 (11.7)	9 (10.1)
Mood swings	<b>13 (13.8)</b>	5 (5.6)
Total <sup>a</sup>	<b>94</b>	<b>89</b>

<sup>a</sup> Nearly all participants listed more than one symptom.  
<sup>b</sup> Highest three frequencies for each type of hormonal therapy shown in bold.

differences between the scores at T3 compared to those at T1 for either of these subscales.

### Functional Assessment of Cancer Therapy-Endocrine Symptoms (FACT-ES)

There were no significant changes in the FACT-ES score over the three time periods, T1 (24.14 ± 13.24), T2 (25.47 ± 16.72) and T3 (22.74 ± 12.41).

### Brief Pain Inventory (BPI)

Approximately 70% of the participants reported at the start of the study that they experienced pain other than the everyday kinds of pain (e.g. minor headaches, sprains, toothache) and, in most cases, the pain was located at one to six different sites throughout the body. Participants who took medication(s) to relieve their pain commonly took paracetamol, painkillers such

Table 3  
Severity and interference scores of pain and fatigue.

Severity/interference	T1 Mean (SD)	T2 Mean (SD)	T3 Mean (SD)
<b>Pain scores</b>			
<sup>a</sup> Mean Pain Severity Score	2.63 (2.04) n = 37	3.66 (1.55) n = 14	3.41 (1.84) n = 16
<sup>b</sup> Mean Pain Interference Score	3.64 (3.01) n = 39	4.16 (2.66) n = 15	3.47 (2.72) n = 18
<b>Fatigue scores</b>			
<sup>c</sup> Mean Fatigue Interference Score	4.81 (2.54) n = 38	3.72 (2.99) n = 16	3.72 (2.59) n = 18
<sup>d</sup> Mean Global Fatigue Score	4.99 (2.21) n = 38	3.87 (2.71) n = 16	3.73 (2.43) n = 17

T1 = Baseline; T2 = Six weeks; T3 = 12 weeks.  
<sup>a</sup> Mean Pain Severity Score = Mean of worst pain + least pain + average pain + pain now.  
<sup>b</sup> Mean Pain Interference Score = Mean of seven interference items.  
<sup>c</sup> Mean Fatigue Interference Score (MFIS) = Mean of six interference items.  
<sup>d</sup> Mean Global Fatigue Score (MGFS) = Mean of fatigue now + usual fatigue + worst fatigue + six interference items (9 items).

as tramadol, and ibuprofen. A few participants also used aromatherapy/massage, meditation, and physiotherapy/osteopathy for pain relief. Most participants who responded said that they experienced relief to varying degrees from the medication(s) or treatment that they had received.

Participants were asked to rate the severity of their pain at its worst and least in the last 24 h, their pain on average and how much pain they had right now. These were summed as the mean pain severity score, which showed a trend to increase over the study period (Table 3). Participants rated how much their pain interfered with their general activity, mood, walking ability, normal work, relations with other people, sleep and enjoyment of life. These items were added together to give a mean pain inter-

Table 2  
Comparison of Profile of Mood States (POMS) questionnaire scores over the study period.

	T1 Mean (SD)	T2 Mean (SD)	T3 Mean (SD)	<sup>a</sup> T1 vs T2 p value	<sup>a</sup> T1 vs T3 p value	<sup>a</sup> T1–T2–T3 p value
Total Mood Disturbance	54.08 (40.91) n = 40	36.12 (44.59) n = 17	38.31 (32.42) n = 16	<b>0.005</b>	<b>0.008</b>	<b>0.001</b>
<b>POMS subscale scores</b>						
Tension/anxiety	13.83 (7.50) n = 40	10.94 (7.79) n = 17	10.35 (6.59) n = 17	<b>0.003</b>	<b>0.028</b>	<b>0.001</b>
Depression/dejection	17.2 (14.4) n = 40	14.47 (14.93) n = 17	13.29 (11.22) n = 17	<b>0.006</b>	<b>0.020</b>	<b>0.010</b>
Anger/hostility	10.30 (9.27) n = 40	9.94 (9.79) n = 17	10.06 (8.00) n = 17	0.082	0.443	0.397
Vigour/activity	12.00 (6.61) n = 40	14.47 (5.43) n = 17	12.31 (5.64) n = 16	<b>0.039</b>	0.776	<b>0.042</b>
Fatigue/inertia	14.33 (6.81) n = 40	7.41 (6.73) n = 17	9.11 (4.61) n = 18	<b>0.008</b>	<b>0.033</b>	<b>0.028</b>
Confusion/bewilderment	10.40 (6.53) n = 40	7.82 (5.27) n = 17	8.41 (4.57) n = 17	<b>0.004</b>	0.131	<b>0.002</b>

Statistically significant differences between time points are shown in bold.  
T1 = Baseline; T2 = Six weeks; T3 = 12 weeks.

<sup>a</sup> Number of paired samples for comparison of time points: T1 vs T2 for POMS subscale scores, n = 17; T1 vs T3 for POMS subscale scores, n = 16; T1–T2–T3 for Total Mood Disturbance and POMS subscale scores, n = 14.



ference score (Table 3). The pain interference score increased at T2, but was decreased at T3 compared to T1.

#### *Brief Fatigue Inventory (BFI)*

All participants who responded, except two ( $n = 28$ ; 93.3%) reported feeling unusually tired or fatigued in the previous week. Participants rated how much their fatigue interfered with their general activity, mood, walking ability, normal work, relations with other people and enjoyment of life. These six items were added together to give a mean fatigue interference score; this score decreased at T2 and remained decreased at T3 compared to T1 (Table 3). In addition, the mean global fatigue score, which comprised three severity (fatigue right now, and usual and worst levels of fatigue in the last 24 h) and the six interference items combined, was decreased at T2 and T3 compared to T1 (Table 3).

#### *Hunter's Hot Flushes and Night Sweats Scale/Hot Flush Diary*

At baseline using the Hunter's Hot Flushes and Night Sweats (HFNS) scale, 21 of 32 (65.6%) participants reported that they had experienced one to ten hot flushes/day in the previous week. In a further six cases, the numbers were higher at 11–16 and above, whilst five participants reported no hot flushes. This was consistent with hot flush diary data from nine individuals which showed a mean of  $5.88 \pm 0.26$  hot flushes per week at baseline. These decreased to  $3.64 \pm 0.45$  at T2, with a further decrease to  $2.19 \pm 0.17$  at T3.

One to five night sweats/night was reported by 21 of 26 (80.8%) respondents in the previous week, whilst five individuals stated that they had no night sweats.

To assess how bothersome hot flushes/night sweats were during the last week, participants rated how much they regarded them as a problem, how distressed they felt about them, and how much they interfered with their daily routine. The problem rating score is a mean of these three items (sum divided by the number of items). The mean problem rating score at baseline ( $4.31 \pm 2.63$ ,  $n = 37$ ) decreased at both T2 ( $3.35 \pm 2.22$ ,  $n = 17$ ) and T3 ( $2.73 \pm 1.76$ ,  $n = 17$ ).

#### *Focus groups and home practice*

The comments made by the five people who attended the focus follow-up group at the London Haven centre focused on how EFT helped them with their personal issues. The main themes that emerged included the following:

- tapping was helpful for physical symptoms such as hot flushes, nausea and pain, and with emotional upsets, coping with life's stresses and when feeling overwhelmed;
- it wasn't necessary to know what specific issue underlies the emotional distress for tapping to work;
- imagining tapping can relieve pain;
- now had more realistic goals for weight loss;
- EFT sessions were more flexible than previous information given about EFT.

The comments made by the four people who attended the focus group at the Leeds Haven centre focused around

the usefulness of being in a group when using EFT. The main themes were:

- everyone had benefited and had made changes on the issue(s) that they had;
- there was a lot of information in the first session and would have liked the whole rather than only half a day;
- they wanted more practice of the technique in the first week and didn't feel confident in using EFT until after the second session;
- they felt supported by the group and learnt a great deal by working with each other;
- they had gained confidence to use EFT to help with emotional as well as physical problems;
- they wanted to continue to explore deeper issues with support and come to a practice group if available.

Home practice sheets were completed by only 11 participants. The amount of time spent by individuals on tapping to address specific issues was generally about 5–20 min, but up to one hour in some cases, on most days of the week.

#### **Discussion**

As far as the authors are aware, this is the first evaluation of the use of EFT as a tool for improving the quality of life of women with breast cancer. The findings of this study suggest that EFT might be helpful for hot flushes/night sweats, fatigue and mood changes experienced by breast cancer patients taking hormonal therapies.

Previous randomised controlled trials have shown EFT to be effective in individuals without cancer for psychological conditions such as anxiety, depression, phobias and Post Traumatic Stress Disorder [19]. In agreement with these findings, this study has shown that women with breast cancer using EFT show a significant improvement in Total Mood Disturbance and all the POMS subscales except for anger across the three time periods (baseline, 6 and 12 weeks). Improvements in Total Mood Disturbance and the anxiety, depression and fatigue subscale scores occurred at both 6 and 12 weeks compared to baseline, consistent with regular use of the self-EFT and/or a sustained effect by the initial EFT sessions. However, vigour and confusion were significantly improved at six weeks, but not at 12 weeks, compared to baseline suggesting that the effects of EFT on these specific domains were not maintained. Information about the time spent by participants practicing EFT at home was obtained from 11 of 18 individuals, indicating regular use for 5–20 min on most days of the week. This may have contributed to maintenance of the beneficial effects of EFT on at least some of the mood domains.

These findings are supported by a service evaluation carried out within the NHS in Sandwell, West Midlands which showed statistically and/or clinically significant improvements in anxiety, depression, psychological distress and self-esteem after a mean of five sessions of EFT, and at 3 months follow up, in patients with a variety of emotional conditions [30].

EFT was also helpful for hot flushes/night sweats which are commonly associated with hormonal use in women with breast

cancer. Although EFT appeared to have no effect on endocrine symptoms as assessed using the FACT-ES questionnaire, the numbers of hot flushes and the mean problem rating score of hot flushes/night sweats were decreased at both 6 and 12 weeks compared to baseline. The baseline mean problem rating score was lower than that previously reported in studies of Cognitive Behavioural Treatment (CBT) for menopausal symptoms in women with and without breast cancer [31,32]. However, the breast cancer patients in the CBT study [31] were eligible only if they had had at least ten problematic hot flushes/night sweats per week for a duration of two months or more, whereas in the present study there was no selection of participants on the basis of symptoms. Furthermore, the decrease in problem rating scores at follow-up were also more marked in these studies than reported here. These differences are likely to be related to both a lower threshold of problematic hot flushes (the floor effect), and the small number of respondents at 6 and 12 week follow-up in the present study.

The lack of a significant change in the FACT-ES score may have been due to the fact that the questionnaire includes, in addition to hot flushes and night sweats, 17 other items covering a variety of other related endocrine symptoms which may have been unaffected by EFT.

EFT was also shown to be helpful for fatigue associated with hormonal therapy use in women with breast cancer. Both fatigue now and the mean fatigue interference score (a measure of how much fatigue interferes with daily life) were notably decreased over the study period at both at 6 and 12 weeks compared to baseline.

The effect of EFT on endocrine symptoms or fatigue has not been previously reported; these findings suggest that further investigation is warranted.

A beneficial effect of EFT on pain has been reported in various studies of other medical conditions, some of which involved randomised controlled trials (RCTs). For example, a significant decrease in physical pain was found in an EFT trial of patients with fibromyalgia, and in another RCT, the frequency and intensity of tension headaches was shown to decrease by more than half and other physical symptoms improved after EFT [33,34]. Although 70% of the participants reported pain other than everyday pain at the start of the study, this evaluation was unable to demonstrate any effect by EFT on pain severity, although there was a decrease in the pain interference score at 12 weeks. In fact, there was a trend towards an increase in pain severity over the study period. This may have been due to increased awareness of pain through the process of learning EFT. An increase in awareness of symptoms has been observed by mindfulness instructors preceding symptom relief associated with mindfulness training in breast cancer patients (Dr Caroline Hoffman, personal communication). The fact that a proportion of the participants were taking medication(s) to relieve their pain with varying degrees of relief may also be of relevance to these findings.

The above quantitative findings were supported by the focus group feedback. Participants stated that they felt that EFT had helped them with their emotional and physical symptoms. They also felt supported by the group and had learnt a lot by working with each other. The value of the intervention as perceived by

the participants was also indicated by the relatively low (15%) drop-out from the study.

In addition, valuable information to guide further studies of teaching self-EFT in a group setting was also obtained. For example, the participants stated that they wanted a longer first session to allow time to take in all the new information and to include more practice of the technique, and also an extra practice session to continue to explore deeper issues with support.

There are some limitations of this study that may affect the validity of the results. As this is a service evaluation, there is no control group and the sample size is small; the notable improvements observed after EFT may therefore be related to factors other than the intervention. These could include the potential effects of other complementary therapies received by about one-third of the participants during the follow-up period. In addition, the outcome measure for pain used in this study (Brief Pain Inventory) does not differentiate between treatment-related pain and any other cause of pain in cancer patients, which may have relevance to the findings. Furthermore, the visitors to the Haven centres are self-selected and so these findings are not necessarily relevant to breast cancer survivors in general across the UK. A further limitation of the study was the reduced numbers of people who completed the follow-up questionnaires at 6 and 12 weeks. Differences in demographic details between those who completed all the questionnaires and those who dropped out or did not complete all three questionnaires were noted, which may have skewed the findings. In addition, the qualitative data from the focus groups was limited and the content analysis unvalidated.

## Conclusions

This service evaluation has shown that EFT shows potential as a self-help tool to manage the side effects associated with hormonal therapies, specifically mood changes, hot flushes/night sweats and fatigue, in women with breast cancer and warrants further research.

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## Conflict of interest

No conflict of interest declared.

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