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*The*  
**SCIENCE**  
*behind*  
**TAPPING**

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A PROVEN STRESS MANAGEMENT  
TECHNIQUE FOR THE  
MIND & BODY

**DR. PETA STAPLETON, Ph.D.**



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# AUTHOR'S NOTE

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Although they are gaining in scientific support, Emotional Freedom Techniques (EFT) and “tapping” are still considered experimental in nature. All information, books, workshops, and trainings are intended to promote awareness of the benefits of learning and applying EFT. However, the general public must take full responsibility for their use of it. The material in this book is for your general knowledge only and is not a substitute for traditional medical attention, counseling, therapy, or advice from a qualified health-care professional.

Neither EFT nor the information here is intended to be used to diagnose, treat, cure, or prevent any disease or disorder. Please note that if you begin tapping and find yourself overwhelmed, distressed, or becoming aware of previously forgotten memories, you may need to seek professional help of a trained and experienced EFT practitioner.

A lack of results or progress may also mean you need professional assistance. If you have any concern regarding your health or mental state, it is recommended that you seek out advice or treatment from a qualified, licensed health-care professional. Before making any changes to your diet, medication, or health plan, it is recommended that you first consult with a doctor, pharmacist, or other qualified medical or health professional.

*All names and identifying details of real clients have been changed to protect their privacy.*

*Chapter*  
*4*

## EFT, TRAUMA, AND PTSD

Sinclair was 27 years old when she first presented for therapy. She had been diagnosed by a psychiatrist with PTSD and discussed a long history of sexual abuse by a family friend since the age of 13. During the years this happened, she was living with an extended family member, as her parents were not able to care for her. She did not disclose any information to any adult, but instead suffered in silence.

When she turned 19 years old, Sinclair moved away to attend college, and the abuse stopped. However, years of drug use and an eating disorder ensued, and then a pregnancy. A year prior to attending therapy and motivated by having her own child, Sinclair started legal proceedings to have her perpetrator jailed. A long court case, which resulted in many other young adults coming forward to say they too had been abused, finally ended and the perpetrator was sentenced.

Sinclair's level of distress, however, did not decrease as a result. The PTSD symptoms she dealt with daily included avoidance of any beaches (as this is where the abuse took place), hypervigilance,

severe anxiety, frequent nightmares and profuse sweating, and social isolation.

She was able to process her traumas with EFT over a six-month period, and now has another child and is in a loving relationship. She describes that while those years of her life were horrific and should never have happened to any child, they are distant memories that have lost their emotional charge. She is able to talk of her perpetrator without fear and no longer meets diagnostic criteria for PTSD.

## WHAT IS PTSD?

In order for someone to be diagnosed with PTSD, a trauma must have happened and symptoms present for at least a month. There are four major types of symptoms that occur for most people after a trauma: reexperiencing the trauma, avoidance of anything that reminds you of the trauma, arousal such as feeling on edge or not sleeping, and negative changes in beliefs and feelings.<sup>1</sup> Other criteria include duration of symptoms, functioning, and that symptoms are not attributable to a substance or co-occurring medical condition.<sup>2</sup>

PTSD can occur in anyone at all, in people of any age, ethnicity, nationality, or culture. PTSD affects approximately 3.5 percent of American adults, and an estimated 1 in 11 people will experience PTSD in their lifetime.<sup>3</sup> There is now also a preschool subtype of PTSD for children ages six years and younger.

While the definition of trauma is different for everyone, the traumatic events most often associated with PTSD for men are rape, combat exposure, childhood neglect, and childhood physical abuse. The most traumatic events for women tend to be rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse.<sup>4</sup>

As you can see, a PTSD diagnosis can be very disabling for a sufferer and interfere with the most basic functioning. While

some people may recover within a few months of a trauma, others can suffer for years.

There are a number of therapy options recommended for PTSD, and EFT as a proposition has been extensively examined. These investigations have demonstrated a substantial reduction in symptoms for sufferers, so let's have a look at the evidence across different areas.

## PTSD IN VETERANS

An initial 2010 EFT study to develop a trauma protocol by Dr. Dawson Church focused on a five-day treatment program for 11 veterans and their family members.<sup>5</sup> They received follow-up 1, 3, and 12 months later as well. The results showed significant improvements in the measures of PTSD symptoms immediately after the five days, and none of the veterans scored in the clinical range for PTSD. The severity and breadth of their psychological distress decreased significantly, and most of the gains held over time. It was the first time EFT as a treatment was presented as being an effective intervention post-deployment.

An observational study of seven veterans (three males and four females) in the same year investigated psychological symptoms change in veterans after six one-hour sessions of EFT delivered over one week.<sup>6</sup> Two different practitioners delivered the EFT intervention, but it was a standardized form. While there was no active comparison group, and follow-up was only at three months, anxiety severity decreased significantly by 46 percent, depression by 49 percent, and PTSD by 50 percent. These gains were also maintained at three months.

In another study of a group of veterans meeting the clinical criteria for PTSD who were randomly assigned to either EFT treatment (30 in total) or standard care (29 in total), those who met the clinical criteria for PTSD and received the six-hour EFT intervention were found to have significant reductions in psychological distress and PTSD symptoms following EFT treatment.<sup>7</sup>

What was quite outstanding was that following both treatments, 90 percent of those who received EFT no longer met criteria for PTSD, compared to only 4 percent in the standard care group (i.e., 96 percent of the standard care group continued to meet the clinical criteria for PTSD following standard care). Three months later, 86 percent of those who received the EFT intervention remained in remission, while 80 percent remained in remission at six months. These results were consistent with other published reports showing EFT's efficacy in treating PTSD and comorbid symptoms and its long-term effects.

A 2016 study reported almost identical outcomes. A study of 58 veterans who scored 50 or greater on the military PTSD checklist (indicating clinical symptom levels) were randomized into a treatment as usual (TAU) group (26 veterans) or an experimental group (32 veterans).<sup>8</sup> The intervention group received six one-hour EFT sessions in addition to TAU. The EFT group showed a significant reduction in a PTSD score from  $65 \pm 8.1$  to  $34 \pm 10.3$ , while those in the TAU group showed no significant change. The TAU group was then treated with EFT and both groups combined for analysis (this is common so that individuals in the former "wait-list" group still receive an intervention).

In the combined EFT group, post-treatment scores declined to an average of 34 (a decrease of 52 percent). The participants maintained these gains at three- and six-month follow-up, with an average six-month score of 34. Psychological conditions such as anxiety and depression also declined significantly, as did physiological markers of insomnia and pain. The study reported an effect size of Cohen's  $d=3.44$  indicating a very large treatment effect.

In a similar vein, 218 male veterans and their spouses attended one of six weeklong retreats to learn EFT and other energy psychology methods (EFT was delivered in a single four-hour group session and then three one-hour individualized sessions).<sup>9</sup> At the end of the week, only 28 percent of veterans still scored in the clinical range for PTSD, and spouses (who had never before been measured in a study) also demonstrated substantial symptom reductions. At the start of the week, 29 percent of spouses met

clinical criteria for PTSD, but at the end, only 4 percent did. The veterans maintained their gains four and six weeks later, and the PTSD symptom decreases also continued for the spouses.

It is important to note that the other options in the study that week included massage, yoga, Reiki, and acupuncture. Furthermore, everyone participated in a half-day equine-assisted therapy session and a Native American ceremony at the beginning and end of the retreat. All of these options may have also impacted the EFT outcomes and PTSD-symptom reduction.

In a recent 2016 study investigating subclinical PTSD symptoms as a risk factor for a later diagnosis, 21 veterans were tracked to see if they developed the disorder.<sup>10</sup> They were randomized into a treatment as usual (TAU) wait-list group and an experimental group, which received TAU plus six sessions of EFT. Symptoms at the start of treatment indicated a score of  $39 \pm 8.7$  on the PTSD Checklist—Military Version (PCL-M), in which a score of 35 or higher indicates increased risk for PTSD. There were no differences between the two groups at the start. The TAU group had no changes during the waiting period and received the EFT treatment at the end of this period.

For the collapsed groups after treatment (because both ended up receiving EFT), there was an average score of 25, which indicated a 64 percent reduction. The veterans maintained their gains at three- and six-month follow-up, with an average score of 27. A Cohen's  $d=1.99$  indicated a large treatment effect. This meant the differences between the veteran and the TAU groups would have been noticeable even to the layman. The study also showed reductions in traumatic brain injury symptoms and insomnia. The authors noted EFT may be protective against a later PTSD diagnosis.

## COMPARISON OF METHOD OF DELIVERY

Does the delivery of the therapy matter? In one of the first studies to compare delivery of EFT via coaches versus licensed

therapists, 59 veterans were randomly allocated to EFT treatment (30 veterans) or a wait-list control group (29 veterans).<sup>11</sup> It is important to note 149 veterans were approached for the treatment, and only those motivated may have volunteered. The participants received six sessions of EFT over a month, with 26 receiving it from a therapist and 33 from a coach. Measures of PTSD included a PTSD checklist and also a symptom-assessment questionnaire.

There was a significant decline in the percentage of veterans still meeting PTSD criteria after only three sessions of EFT: 47 percent still met it in the coach condition, while only 30 percent still met it in the therapist condition. However, improvements continued afterward; and at the six-session mark, only 17 percent of the coach condition and 10 percent of the therapist condition still met criteria. These gains were also maintained three months later. While the statistical differences between the coaches and therapists were nonsignificant, the therapist group did have lower levels of psychological distress at the end.

The method of delivery of EFT has been investigated with PTSD veteran sufferers, and a comparison of traditional face-to-face delivery versus telephone delivery showed positive outcomes.<sup>12</sup> Each group received six one-hour EFT sessions, which were manualized for standardization. In total, 24 veterans received telephone sessions, and 25 received face-to-face sessions. The telephone group improved significantly in PTSD symptoms after the six sessions, whereas the face-to-face group only took three sessions to achieve these gains.

After six months, 91 percent of the face-to-face group no longer met criteria for PTSD, but only 67 percent of those treated via telephone no longer met it. While there was no comparison treatment, and veterans self-selected to the two groups rather than being randomly allocated, telephone delivery was effective for two-thirds of patients. It suggested that for some it might be a viable alternative for those unable to attend face-to-face sessions.

## COMPARISON OF EFT TO OTHER APPROACHES FOR PTSD

EFT has been compared to EMDR for PTSD in 46 adults (the U.S. Department of Veterans Affairs has accepted EMDR as a viable treatment for veterans with PTSD).<sup>13</sup> In this study the participants were randomly allocated to EFT or EMDR (23 in each), and results indicated *both* interventions produced significant outcomes at the end of treatment and three-month follow-up. While a slightly higher proportion of EMDR patients showed substantial clinical changes, the treatment effects were similar in both groups. Given EMDR is accepted as an evidence-based treatment, and EFT achieves similar outcomes in clinical trials, then it is a logical next step to consider EFT as a viable option.

An evaluation of EFT and Narrative exposure therapy (NET) as treatments for PTSD investigated 60 male Iraqi students who met the DSM-IV PTSD criteria and were aged between 16 and 19 years.<sup>14</sup> They were randomly divided into three groups, with 20 participants in each group. The EFT and NET groups received four therapy sessions each, while the control group received no treatment.

The EFT group reported a significant difference in all PTSD cluster symptoms, although the NET group only reported a significant difference in avoidance and reexperience (not hyperarousal). There were no significant differences between the groups relating to social support, coping strategies, and religious coping. These changes were maintained for the EFT group at 3-, 6- and 12-month follow-up; and the effect size of EFT was higher than NET and the control group, thus indicating that EFT was more effective than NET.

And finally, a 2015 publication reported on a comparison between cognitive behavioral therapy (CBT) and EFT for sexual gender-based violence (SGBV).<sup>15</sup> The study included 50 internally displaced female refugees who had been victims of SGBV in the Democratic Republic of Congo (DRC). They all received two two-and-a-half-hour treatment sessions per week for four consecutive weeks (eight sessions in total). The women indicated significant

post-test improvement in both groups on measures of trauma, PTSD symptoms, and general mental health. They also maintained their gains whether treated with EFT or CBT, and overall demonstrated the effectiveness and non-inferiority of EFT to a gold standard intervention.

## THE IMPORTANT REVIEWS

A systematic review assessing the evidence for 15 new or novel interventions for the treatment of PTSD found there were four interventions with moderate-quality evidence from mostly small- to moderate-sized randomized controlled trials.<sup>16</sup> One of the named interventions was EFT. The important thing about this study was it was led by an independent university with impartial researchers.

Another systematic review of seven studies investigating EFT in the treatment of PTSD found a very large treatment effect (weighted Cohen's  $d=2.96$ , 95 percent CI 1.96-3.97;  $p < 0.001$ ) for the studies that compared EFT to usual care or a wait list. Remember, above 0.8 for Cohen's  $d$  indicates a large treatment effect, and this review found an effect of 2.96!

The authors used the APA standards as their quality-control criteria when selecting studies for inclusion, and also found that a series of 4 to 10 EFT sessions was an efficacious treatment with *no adverse effects* for PTSD with a variety of populations.<sup>17</sup> When we talk about the speed of EFT, this is precisely what we mean.

In 2017 Drs. Church and Feinstein reviewed all the Clinical EFT research to date for PTSD with a focus on veterans and service members. The published studies indicate that PTSD symptoms are typically improved in very few sessions—ranging from one session for a phobia to 4 to 10 sessions for PTSD. EFT is considered especially suitable for veterans and military for these seven reasons:<sup>18</sup>

1. The depth and breadth of treatment effects
2. The relatively brief time frames required for successful treatment

3. The low risk of adverse events
4. The minimal training time required for the approach to be applied effectively
5. The simultaneous reduction of physical and psychological symptoms
6. The utility and cost-effectiveness of Clinical EFT in a large-group format
7. The method's adaptability to online and telemedicine applications

## TRAUMA

The application of EFT for general trauma outside of PTSD has also been studied.

Ten adults who had been in an auto accident (within the past year) and were continuing to suffer from reported moderate to severe traumatic stress received two sessions of EFT.<sup>19</sup> All clients had brain-wave assessments (using a quantitative electroencephalograph, qEEG) before and after EFT treatment. They also completed questionnaires relating to anxiety, depression, and avoidance of driving/riding in a motor vehicle. Everyone reported positive change immediately after the EFT treatment, but four reported no or negative changes at the time of the last brain assessment.

Those who reported the benefit of EFT had increased 13–15 Hz amplitude over the sensory motor cortex, decreased right frontal cortex arousal, and an increased 3–7 Hz / 16–25 Hz ratio in the occiput (back of the head). The authors hypothesized that the improved subjects may have been more compliant with treatment recommendations whereas the unimproved clients were not. This is not an uncommon phenomenon across many therapeutic modalities.

Following the 2010 Haitian earthquake, which did widespread damage, 77 male seminarians were assessed for PTSD.<sup>20</sup> The purpose of this study was to evaluate EFT delivery to a traumatized

population, and 48 of the men (62 percent) exhibited scores in the clinical range for PTSD. While the study lacked a control group, after two days of EFT, not a single participant scored in the clinical range on the PTSD measure—this was an outstanding result. The average reduction of PTSD symptoms was 72 percent after the two days. The results were consistent with other studies and pointed to the potential of EFT for those experiencing natural disasters.

A project called “Change Is Possible” in the San Quentin State Prison in California has offered EFT to life-sentence and war-veteran inmates for some years. Prisoners generally receive five sessions of EFT from a trained practitioner, with a three-session supplement one month later.<sup>21</sup> Similarly, another study randomized 16 males (aged 12 to 17) from an institution to which juveniles were sent by court order. This was usually due to being physically or psychologically abused at home.<sup>22</sup> In this study the teens were assessed with a SUD rating and the Impact of Event Scale, which measures two components of PTSD: intrusive memories and avoidance symptoms.

One group was treated with a single session of EFT, and the wait-list control group received no treatment. Thirty days later, participants were reassessed and there was no improvement for the wait list, but posttest scores for the EFT group improved to the point where all were nonclinical on the total score, as well as the intrusive and avoidant symptom subscales and SUD ratings. This was an outstanding result and consistent with studies in adults. It again points to the impact EFT has after relatively few sessions.

## THE MECHANISM OF CHANGE

So why does EFT actually work for PTSD and trauma? Dr. David Feinstein, clinical psychologist and an internationally recognized leader in the field of energy psychology, offers some reasons.<sup>23</sup> Dr. Feinstein suggests that combining the brief psychological exposure of EFT with the manual stimulation of acupoints integrates established clinical principles. In 2010 he reviewed

two randomized controlled trials and six outcome studies with military veterans, disaster survivors, and other traumatized individuals, and suggested that tapping on selected acupoints during imaginal exposure *quickly and permanently* reduces maladaptive fear responses to traumatic memories and related cues.

At the time this was a controversial approach, and the speed at which EFT was working in this field was unheard of. Feinstein proposed deactivating signals were being sent directly to the amygdala (brain stress center), resulting in the rapid decrease of threat responses to things that were benign.

Furthering the memory reconsolidation proposal in Chapter 3, one of my own doctor of philosophy graduates Mahima Kalla (Monash University, Melbourne) also raised the notion that memory reconsolidation mechanisms may be utilized for therapeutic change in neuropsychiatric disorders such as PTSD and phobias.<sup>24</sup> Kalla wrote that maladaptive fear memories, usually attributed to Pavlovian associations, are considered to be at the crux of these disorders. This means fears become associated with benign or neutral things, as Pavlov famously linked food and the sound of a bell for his dogs by ringing it when feeding them. They eventually salivated with the sound of a bell ringing in the absence of any food being presented. If abuse happens to someone in a certain room, often a neutral item might set off the trauma response because it has become associated with the abuse (e.g., the color of a chair).

The memory reconsolidation theory suggests that upon retrieval, the trauma memories become labile (easy to change) for a few hours. During this time, expectancy violation or prediction error can induce memory destabilization and lead to therapeutic change. This particular article proposed that EFT can specifically be used to reconsolidate memory and therapeutic change. The EFT protocol combines three crucial elements of therapeutic change: retrieval of fear memories (the exposure aspect); incorporation of new emotional experiences and learnings into the memory, creating a prediction error (after the acupoint tapping); and finally reinforcement of the new learning (which we see in follow-up aspects of studies). This is commensurate with Feinstein's

and others' suggestions and may not be as radical as originally believed.<sup>25,26</sup>

## PRACTICAL TIPS FOR USING EFT FOR PTSD

In 2017, clinical best practice guidelines for the use of EFT to treat PTSD, were proposed.<sup>27</sup> In a survey of 448 EFT practitioners, a “stepped care” treatment model used by the United Kingdom’s National Institute for Health and Clinical Excellence (NICE) was used to inform guidelines. Most practitioners (63 percent) reported that even complex PTSD can be remediated in *10 or fewer EFT sessions*. Some 65 percent of practitioners found that more than 60 percent of PTSD clients are fully rehabilitated, and 89 percent stated that less than 10 percent of clients make little or no progress.

Based on this feedback, the authors recommended a stepped-care model, with 5 EFT therapy sessions for subclinical PTSD (when it doesn’t quite meet full diagnosis) and 10 sessions for clinical PTSD, in addition to group therapy, online self-help resources, and social support.

### Overview of the Clinical Guidelines

The authors suggested the risk of PTSD should be mitigated using a proactive approach to develop resiliency. In the NICE model, the patient is offered the least intrusive potentially effective intervention first. If the patient does not benefit, or prefers not to continue, the next step is offered. The NICE guidelines emphasize the importance of integrated care, because many mental-health conditions share similar neural pathways.

**Step 1:** Involves identification, assessment, psychoeducation, active monitoring, and referral for further assessment and interventions. NICE recommends using the PTSD Checklist (PCL); and in a military population, a score of 35 or greater indicates PTSD

risk probability.<sup>28</sup> The PCL is a 20-item self-report measure that assesses the 20 symptoms of PTSD according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The PCL has a variety of purposes, including the following:

- screening individuals for PTSD
- making a provisional PTSD diagnosis
- monitoring symptom change during and after treatment

**Step 2:** NICE recommends treatment using Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) or EMDR. These recommendations do not include EFT because most of the earlier referenced studies had not been published at the time the guidelines were developed. The authors of the clinical-practice guidelines for the use of EFT to treat PTSD have recommended an update of the guidelines based on currently published research.

### When Clinical Scores are 35 to 49 in Initial Assessment

For subclinical scores (35 to 49) in the initial assessment (PCL), the EFT clinical guidelines recommend that treatment should be as usual, plus these steps:

1. Five individual EFT therapy sessions
2. One instructional session on using the BATTLE TAP interactive online coach
3. Three Borrowing Benefits group therapy sessions (If members of the client's family are willing and able to attend a Borrowing Benefits sessions, they should be invited.)

BATTLE TAP is an interactive virtual EFT-coaching software program, a “ready-to-use” adaptation of EFT created by founder Gary Craig.<sup>29</sup> Borrowing Benefits is the notion that simply watching someone else do EFT on their issues while tapping along with

them can help you reduce the emotional intensity of your own issues (see Chapter 1).

Dr. Church and colleagues suggest that if symptoms are still above 34 (PCL score) when step 1 is complete, then three more sessions plus an additional BATTLE TAP instructional session be carried out. Three months after the final therapy session, if symptom levels are still above 34, monitoring the client and performing regular follow-up assessments are recommended.

### When Clinical Scores Are > 49 in Initial Assessment

Treatment as usual should occur as well as these steps:

1. 10 individual EFT therapy sessions
2. Two sessions using BATTLE TAP
3. Five Borrowing Benefits group sessions (If members of the client's family are willing and able to attend Borrowing Benefits sessions, they should be invited.)

If symptom levels are persistently above 40 after the above has been conducted, then they recommend three more individual therapy sessions and an additional BATTLE TAP session, as well as five additional Borrowing Benefits group sessions.

Three months after the final therapy session, if clinical symptoms still persist, the authors recommend escalating intervention to steps 3 and 4 of the NICE guidelines, which advocate appropriate medication and intensive individual psychotherapy.

### A Proactive Approach for Using EFT for Active-Duty Military

Dr. Church and colleagues in the above study also advocate for a proactive approach using psychoeducation and Borrowing Benefits to mitigate the risk of development of symptoms in active-duty military. This is a unique and potentially powerful approach. It has two arms:

- *Pre-deployment Component:* Independent of the PCL-M assessment, three days of group EFT training using Borrowing Benefits as stress-inoculation therapy, including an introduction to BATTLE TAP is recommended.
- *Post-deployment Component:* Independent of the PCL-M assessment, seven days of group EFT therapy using Borrowing Benefits and BATTLE TAP are recommended. Practitioners are to offer individual psychotherapy sessions if requested by active-duty military.

## NOTES FROM A PRACTITIONER

Julie Vandermaat, a sexual assault counselor in Australia, shared this story with me of working with “Stella,” a young Aboriginal woman. Stella was referred by her medical practitioner for PTSD, anxiety, and depression caused by childhood trauma. For years she had been going to appointments with psychologists and psychiatrists, and while she did everything suggested, her symptoms did not improve.

As a teenager Stella used to cut herself. She tried to kill herself and ended up in the mental-health inpatient unit a number of times. As time went on, she no longer wanted to end her life—all she wanted to do was feel better.

Julie was the last counselor Stella was going to try.

At her first appointment, Stella was so anxious she was visibly shaking. She explained it took her lots of courage to come to that first appointment. But she engaged very well and was able to talk about being exposed to a lot of violence and drug and alcohol abuse while growing up.

Stella explained she had been sexually assaulted a few times, but the worst trauma was being violently sexually assaulted by a trusted adult family member when she was a teenager. She

reported this to the police, had a forensic medical examination, and the perpetrator was jailed. However, she was still traumatized.

Stella reported at the first session that she was barely leaving her house. She was “petrified” that the perpetrator or another family member could find her and hurt her. She was hypervigilant, and always kept her back to the wall. Her PTSD score was 47 out of 60 on the Child and Adolescent Trauma Screening questionnaire, and on the Hospital Anxiety and Depression Scale she scored 16 for anxiety (severe) and 11 for depression (moderate).

Her mood was 3 out of 10, and her sleep was terrible as she was startled by any noise. She never felt hungry, as she felt physically sick all the time. Stella explained that food triggered her to think about all the happy times and meals that used to be shared together in her big extended family.

But since the sexual assault, Stella lost most of that family support, as only a handful of family members believed and supported her when she reported the crime. Most people blamed her, or thought she lied. She also washed her hands 20 times an hour, as she always felt dirty. “I can’t get myself clean,” she said, and her hands were cracked and sore.

The first EFT session focused mainly on fear: that the abuse could happen again, or that the perpetrator or a family member might find her and hurt her. This was 10 out of 10 for Stella. Julie also focused on shame, feeling “dirty” and “not human” as these were also 10 out of 10 for Stella. In her body, Stella felt this mostly in her stomach, where she was constantly nauseated, and she described this feeling as black in color.

After the first EFT session, Stella was relaxed, laughing, and smiling and rated her feelings as 6 out of 10. When she left, Stella stated she felt more hopeful that maybe there was something that could help her. After that EFT session, she said she had “the best sleep ever,” and was more able to eat without feeling so sick.

Stella explained at the second session that many of the thoughts were still there, but that she was able to just acknowledge them without getting caught up in them. She said, “I’m not letting the thoughts define me anymore.”

The second session focused on “Am I normal?” and Stella was able to reframe her trauma. She said that through this experience, she was able to save her mother and herself from further exposure to drugs, violence, and sexual assault, which she felt was considered “normal” in the culture of her extended family.

By the third appointment, Stella reported her anxiety was much better, rating it as 4 out 10 during the day, although still very high at night. Stella mentioned that after two sessions of EFT, she was finally able to relax enough to close her eyes in the shower, and this was something she hadn’t done in years. She was very happy with the sessions. At the fourth appointment, her screening measures had not changed much, but her reflections were:

“I feel human now. I am as normal as I can be, considering what has happened to me.”

“My life is not ‘stuffed.’ It has been affected, but I can live with it (the trauma) now and work through it.”

“I am okay. I am not useless. I can help somebody else through sharing my experience, and that makes me feel good about myself and proud of myself.”

Stella was only washing her hands about 20 times a day (not per hour). Her hands looked smooth, and the skin was healthy. She rated her shame feeling as 4 out of 10—which she said was “a normal part of being Aboriginal.” (Julie felt very sad to hear this, but Stella was accepting of the situation.) She rated her general mood as 5 out of 10 and described a lot more self-love and self-acceptance. She said, “I am content with my body now.”

Julie then asked Stella to join her to speak about EFT to a forum of youth mental-health professionals. It was an informal end-of-year meeting, focusing on “what has worked well in 2017.” Stella was enthusiastic about the idea and said, “I am still anxious and nervous at times, but I know I am safe.”

Stella spoke beautifully at the forum, and the audience was stunned. She talked about how she liked EFT as it felt safe and gentle. She described feeling in control of the process while she is tapping. Stella also appreciated that she decides what the sessions focus on. She said she has found more hope through a few sessions

of EFT than she has in years of traditional talk therapy, which inspired her to want to share her journey to help others who have experienced similar traumas.

Julie called Stella a true inspiration to her as a therapist.

## TAKE-HOME POINTS

PTSD can be a debilitating disorder, and 8 percent of Americans (24.4 million) have PTSD at any given time.<sup>30</sup> The Veterans Stress Project, an initiative of the National Institute for Integrative Healthcare (NIIH), is determined to make a difference when it comes to PTSD related to combat or military service. They are a movement offering veterans free or low-cost sessions using EFT. To access the services, please visit [www.stressproject.org](http://www.stressproject.org). You can get in touch with a veteran who has used EFT to recover from PTSD through the website and read stories of their journey.

In a very exciting move, in October 2017 the U.S. Veterans Administration (VA) approved EFT. After reviewing the extensive evidence for the safety and efficacy of EFT, a group of experts in the VA's Integrative Health Coordinating Center published a statement approving EFT and several other complementary and integrative health (CIH) practices. They stated that based on the study by "the expert scientific community (both internal and external to VHA) knowledgeable about the safety of CIH approaches," EFT and several other methods including Healing Touch, acupressure, and Reiki, are "generally considered safe."<sup>31</sup>

EFT is remarkably quick to work and has the ability to efficiently pair a neutral or even calming response with a traumatic memory. This results in a unique detachment for the client, but one that gives them a great sense of control and ultimately peace. With a tool such as tapping available for returning war veterans, or in the hands of existing therapists, trauma may be more readily processed and complex syndromes might actually be avoided.