Emotional Freedom Techniques

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Emotional Freedom Techniques: A Safe Treatment Intervention for Many Trauma Based Issues

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SUMMARY. Callahan (1985) developed a procedure of tapping on acupressure points for treating mental problems. Craig and Fowlie (1995) modified Callahan's procedure to a simplified version called Emotional Freedom Techniques (EFT). EFT is easy to teach and is effective with symptoms of PTSD. This article presents EFT as an adjunct to the Critical Incident Stress Reduction debriefing procedures. The use of EFT in debriefings results in shorter and more thorough sessions. It often reduces the emotional pain of the debriefing. This paper provides complete instructions and safeguards for using EFT when debriefing in disaster situations and with other applications. Included are references for further reading and training. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com>*

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Craig and Fowlie (1995) developed a technique for neutralizing traumatic memories called Emotional Freedom Techniques (EFT). In this treatment intervention, the patient taps on acupuncture points to neutralize the emotions associated with a traumatic experiences or beliefs. Because EFT is a very safe and simple method to learn and use, it was initially taught as a personal performance technique. In clinical practice, EFT has been shown to be effective for the treatment of many trauma-based issues. It is a useful intervention for mental health professionals and paraprofessionals to use, as well as for sharing among friends and family. This article is intended to teach the method at a practical level, thereby enabling the reader to experiment with it. In addition, the reader will be instructed in ways to integrate the EFT method with Critical Incident Stress Debriefing (CISD; Mitchell & Everly, 1996). The use of EFT often allows debriefings to be much shorter and thorough and often reduces the emotional pain of the debriefing.

OVERVIEW

Background and History

EFT is a modification of Callahan's (1985) Thought Field Therapy (TFT). Callahan studied Applied Kinesiology and extended the work of Goodheart (1964-78) and Diamond (1985) to mental health issues. Callahan discovered that muscle-testing points on each of the twelve major acupuncture meridians while the patient was thinking about a specific issue allows one to identify the sequence of acupressure points associated with that issue. His work led to the development of standardized sequences of acupressure points to use with issues typically seen in his students and clients. Roger Craig, one of Callahan's students, however, discovered that the sequences used were usually not important and that results similar to Callahan's could be obtained simply by tapping on all twelve acupressure points (Craig, 2000a). This finding greatly simplified the procedure for application and teaching.

There are many theories explaining the treatment process in EFT. It seems relatively clear that it is a learning process because change occurs; however, the mechanism of the active ingredients of change, like EMDR,

are not yet known. Energy psychologists believe that the change process has to do with altering body energies that are represented in the meridians, while Flint (1994) believes that change is caused by a learning process triggered by stimulation. In either case, the EFT intervention works extremely well.

Efficacy Research

Presently, research on the efficacy of TFT and EFT remains sparse. Due to lack of quality research demonstrating the effectiveness of these treatment methods, both TFT and EFT are still considered to be experimental interventions. However, preliminary studies have offered promising results. Carbonell and Figley (1999), for example, carried out a three-year research project in which they tried to find out the active ingredients of therapeutic change among four therapies, including TFT. Results of this study suggested that TFT was as effective, if not more so, than the other more proved therapies examined. Figley (1995) stated that TFT was extraordinarily powerful, easily taught, and can produce fast and long lasting results, and did no harm. They also concluded that it was a successful treatment method in most of the trauma cases treated regardless of the exact tapping sequence used by the practitioner. In addition, Craig (2000a) believes there is no difference between the effectiveness of EFT and TFT.

Callahan and Callahan (2000, p. 50) cite two studies, each with 68 subjects, that involved treating phobias and anxieties over the telephone therapy while on radio talk shows. Callahan did the first unpublished study in 1986 for which he used a standard tapping algorithm for treatment. Leonoff (1995, p. 1), then, repeated Callahan's study in a different way. He used Voice Technology (VT) to determine over the telephone the exact treatment sequence for the caller's issue. The results of Leonoff's study published with Callahan's results were almost identical with Callahan's original study (Callahan & Callahan, 2000, p. 50). The average decrease in experienced distress for treated participants was 74% or better, and the average amount of time needed to achieve the results was less than 6.04 minutes, which indicates that TFT causes changes very quickly. TFT and EFT practitioners often find similar rapid results in their clinical practices.

Recently, Andrade and Feinstein (2002, p. 2) published preliminary results of in-house studies of the tapping therapies, TFT and EFT, based on 29,000 patients. Overall, they found better than 70% effectiveness with the tapping treatment. An additional study compared tapping treat-

ment versus Cognitive Behavior Therapy with medication (CBT/M; Andrade & Feinstein, 2002, p. 3). The study extended over a five-and-one-half year period ($N = 5000$), and looked at anxiety disorders, including diagnoses of panic, agoraphobia, social phobias, specific phobias, obsessive compulsive disorders, generalized anxiety disorders, PTSD, and acute stress disorders; and somatoform disorders, eating disorders, ADHD, and addiction disorders. The patients, selected from 11 clinics in Uruguay and Argentina, were randomly assigned to each group. The data collected on these patients were intake history, record of the procedures used, clinical responses and double-blind follow-up interviews by telephone or in person at one, three, six, and twelve months. Positive responses to treatment "ranging from complete relief to partial relief to short relief with relapses" were found in 63% of the CBT/M group and 90% of the tapping group. Further, 52% of the CBT/M group and 76% of the tapping group found complete relief from symptoms.

Andrade and Feinstein (2002, p. 4) cite another study that compared CBT/M to a tapping/dissociation treatment in assessing the number of treatment sessions to completion ($N = 200$). In the latter group, tapping and VK dissociation techniques were used as needed. VK dissociation involves the patient viewing the trauma as a movie while manipulating sensory qualities of the movie by imagining a tactile, color, or auditory distortion. The results showed that it took an average of 15 sessions for the CBT/M group and an average of 3 sessions for the tapping/dissociation group. The results of these studies suggest the tapping treatment is safe, effective, and efficient.

EFT Is a Practical Treatment Method

EFT is a treatment method that is easy to learn (Craig & Fowlie, 1995). This treatment is effective with most anxiety or trauma based issues, has remarkable effect with pain by treating remembered pain that contributes to chronic pain, is extremely safe, easy to teach, is a natural self-help treatment intervention (Callahan & Callahan, 2000; Durlacher, 1994; Flint, 2001), and can be taught to and used voluntarily by children. The effects of EFT treatment are usually immediately experienced and are long lasting.

The information given in this article will be sufficient to treat many trauma-based issues. More extensive instruction is available from a manual and videotape course produced by Craig and Fowlie (1995) as well as the book entitled *Emotional Freedom* (Flint, 2001), which presents the

content of Craig and Foulie's (1995) videotape course. Craig's (2000b) Web site has case histories of many mental and physical issues.

Treatment with EFT is usually very effective and reliable (Craig & Fowlie, 1995, p. 114). The worst that can happen seems to be that the treatment method does not work. Very few clients report getting upset when tapping acupuncture points (Craig & Fowlie, 1995, p. 39). In such cases when upsets occur, the meridian acupressure points can be stimulated through touching or breathing to reduce the intensity of the emotional pain (Diepold, 2000). With clients who have complex trauma, psychosis, and Dissociative Identity Disorder, EFT should be not be used as a stand-alone treatment technique and cannot replace long-term psychotherapy. In this case, it can be an additional tool once the therapeutic relationship has been firmly established. The authors recommend that only professional therapists treat persons in acute crisis, persons who are currently in therapy, or those who have a history of hospitalizations.

Skill Level Required

Non-clinicians can be taught to use EFT. Therapists routinely teach their clients to use EFT and TFT on themselves at home. These clients often report that they were able to teach relatives to effectively use and benefit from this technique. In all cases, common sense precautions should be used. If the person using EFT experiences intense fear or negative emotions while being treated by a layperson, the method should be terminated and the client should be advised to find a professional therapist.

EFT may also be a useful adjunct to CISD, as mental health workers, nurses, clergy, and others who conduct CISD sessions can use it. CISD involves cognitive debriefings in which survivors are able to share and verbalize their experiences, with the support of fellow survivors, and process the traumatic events in a healthy way (Mitchell & Everly, 1996). Used as a tool for reducing traumatic stress, therefore, EFT may be a particularly useful after initial crisis counseling.

EFT, however, cannot replace psychotherapy for the treatment of severe trauma. Therefore, when persons are suffering from PTSD or are in crisis, the mental health worker will still need to develop rapport with the client, take a brief history, assess suicidal risk, and rule out dissociative processes. These persons should be carefully evaluated to determine whether a referral to a professional psychotherapist is appropriate.

INSTRUCTIONS FOR USING THE EFT METHOD

Basic Recipe for Using EFT

There are basically two steps to learning and using EFT. First, one must learn to identify the issues and aspects with which to work. Second, one must learn the EFT treatment method itself. The goal of the first step is to identify the important aspects of each issue presented by the client, to describe them in a sentence, and to then generate a reminder phrase. The goal of the reminder phrase is to help the client keep focused on the emotional content of the issue during the treatment. The second step (i.e., to learn the treatment method) involves tapping on acupressure points. There are two methods. The first is a sequence that requires tapping on 12 acupressure points. The second, the 9-Gamut, requires tapping on the back of the hand and doing eye movements and vocalizing. This will be described in detail later. The EFT method can be used to treat the important aspects of any issue.

When learning the EFT tapping intervention, the mental health worker must follow the treatment instructions very carefully. The authors recommend memorizing the basic steps of EFT, which are as follows: (a) Forming the positive affirmation joined with a reminder phrase, or a phrase that keeps the issue in your thoughts; (b) Measuring the emotional intensity of the issue or aspect on a scale ranging from 0 to 10; (c) Applying the affirmation or modified affirmation; (d) Tapping on acupressure points described later as the sequence, the 9-Gamut treatment, and then repeating the sequence; (e) Troubleshooting when the healing process has stopped; and (f) Doing steps b through e (i.e., a treatment cycle) until the emotional level of the issue or aspect is reduced to a scale of zero (Flint, 2001, p. 33). Some steps in this "basic recipe" can occasionally be omitted without losing effectiveness (Flint, 2001, p. 36). However, it is recommended that the complete EFT method be used to insure maximum effectiveness both when learning it and when using it in situations where contact with the clients may be time limited.

Identifying Aspects of the Issues for Treatment

Clients will have issues with multiple aspects that have to be treated (Flint, 2001, p. 15). For this reason, it is always useful to ask if there are any other beliefs or experiences that are related to the issues identified by the client. The mental health worker should have the client write

down all aspects of the issue chosen for treatment as descriptive sentences and include key words, for example, "I feel empty with all my losses." It is important to describe each aspect of the issue as specifically as possible.

Furthermore, when obtaining descriptive sentences of aspects, the mental health professional should focus on specific visual or auditory perceptions ("my cat's eyes," or "the breathing of the victim next to me,") or use a description of the emotion in its context ("My fear, when I saw the truck driving into the train."). In addition, the emotions should be described as adjectives, rather than as nouns (e.g., not "emptiness" but "empty"; not "anger" but "angry"). Emotions are active processes. The authors believe that when nouns are used to describe emotions, they seem to consolidate and become less accessible. Using an adjective, a process word, suggests and maintains active emotions, which allows for rapid treatment.

The descriptive sentence will then be used to elicit the emotion associated with the related aspect of the issue being treated. Through the use of such descriptive sentences, the mental health worker is able to get a measure of the pretreatment intensity of the painful emotion elicited by the individual aspects of the issue. Each individual aspect or component of a larger issue may include memories that are visual, auditory, tactile, or olfactory in nature. They may also include beliefs and emotions associated with the loss of tangible items.

Treating the individual aspects of a trauma with EFT often leads to rapid positive change (Craig & Fowlie, 1995, p. 70). When there is no change in one's thinking or emotional reactivity toward some aspect of the trauma, the aspect can become a new issue to be treated because of its complexity. In such cases, the new issue becomes independent of the original trauma issue from which it came and needs to be treated separately. The new issue may be found to have multiple aspects to treat.

Appropriate Issues for Treatment

In the initial stage of learning the method, EFT can be used on oneself, family, and friends. Initially, the mental health worker can try it on simple phobias, such as a fear of public speaking or spiders. Avoid phobias based upon severe trauma, such as a phobia caused by a severe accident or by an animal attack. For some people, thinking about these phobias generates emotions that may be difficult for a beginner to handle or may be beyond their initial skill level. As confidence builds, EFT can be used on other less painful issues or aspects. When confidence is

strong, the mental health worker can use EFT on more difficult issues and aspects.

In disaster situations, for example, the mental health provider should try to keep the treatment focused on the specific trauma of the disaster rather than on the general emotions elicited by the event. This is done to avoid triggering old traumas associated with those emotions. The focus of treatment can be better controlled if the disaster is treated as a movie and the treatment focuses only on the emotions and memories associated with each traumatic frame of that movie. The frames of the movie become different aspects of the disaster that can be safely treated separately (Flint, 2001, p. 15). For example, the emotion "terror" could be connected not only to the disaster being discussed, but also to other events from the client's past. Therefore, focusing on the emotion of "terror," rather than on the specifics of the disaster situation, may leave the client vulnerable to being traumatized by memories associated with any past event that was also experienced as terrifying. Therefore, to keep the client focused on the presenting trauma, the client's reminder phrase should be specific to the current trauma (e.g., "terror of the forest fire"). Also, by focusing on the specific "frames" depicting the event (e.g., "the exploding tree") all of the emotions connected to this frame can be neutralized during the EFT process. The goal of treatment is to allow the client to be able to look neutrally at the mental pictures (frames) depicting the disaster situation (e.g., the exploding tree).

The following vignette is a clinical example of the application of this strategy. A railroad engineer witnessed another man's suicide. The man was sitting between the rails and looked directly into the eyes of the engineer as the train ran over him. EFT treatment focused on the client's view of the man's eyes prior to the crash and body parts after the crash. After using EFT, the engineer was able to remember the incident calmly, saying: "It was his choice, I couldn't help it."

The Reminder Phase

Once the aspects of a chosen issue are identified, a reminder phrase is designed to keep the trauma memory active so that tapping treatment can effectively change the memory. When you are not thinking about the issue, the trauma memory is not active. The memory of the issue has to be active for the treatment process to work. Saying the reminder phrase keeps the memory of the trauma issue active. Expanding on the above forest fire example, the specific aspects associated with this trauma can be organized into those depicted in Table 1.

TABLE 1. Traumatic Aspects Associated with Forest Fire Example

Issue	Aspect	Reminder Phrase for
Aspect		
The forest fire exploding tree	I have flashbacks to the fire.	That
	I feel empty with all my losses.	Empty
	I feel grief over the loss of my cat.	My cat grief
	I can still smell the situation.	That smell
	I feel devastated by losing my home.	This loss

Obtaining a Measure of Emotional Intensity

Obtaining a measure of emotional intensity is the first step in EFT treatment. The mental health worker has the client measure the intensity of his or her distress over the chosen issue on the Subjective Units of Distress (SUD) scale. This self-report measure was used in Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1995, p. 70). A SUD level of 0 indicates no emotional distress, while a SUD level at 10 is very intense emotional distress. Having clients periodically rate their level of distress on the 11-point SUD scale allows the mental health worker to detect changes in the client's or group's subjective experience of trauma symptoms as treatment progresses.

When working with an individual, the mental health worker initially asks the client to estimate the SUD that best describes the intensity of his or her emotion after reciting the descriptive statement created for each aspect of the issue being treated. Guessing is acceptable when the client is unable to estimate the level of distress that the statement will elicit, since it is a subjective measure and a guess is as good as anything. These estimations or guesses provide a baseline level of emotional distress for that issue. Then, after each treatment cycle, the SUD level is reassessed to monitor the effects of the treatment. Assessing emotional intensity is an important part of EFT treatment because a comparison of the client's SUD scores is used to determine whether to stop the treatment, to do another treatment cycle, or to troubleshoot by using corrections to remove the barrier blocking the effectiveness of the treatment when no change in the level of distress is detected.

When conducting CISD with groups, the debriefer introduces the concept of the SUD measure at the beginning of the group CISD pro-

cess. The debriefer has the participants monitor their own SUD levels during the formal CISD process by asking for a show of hands for different intervals of SUD levels (e.g., 9 to 10, 7 to 8, etc.). The debriefer keeps a tally of the number of group members that endorse each interval. This process is repeated periodically throughout the debriefing. The changing tally shows the group members the effectiveness of the CISD process and indicates those members who are still having problems. This protocol may also set the stage for introducing EFT as another method to further lower the SUD levels.

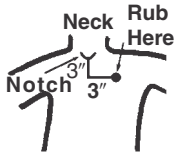
It is important to be flexible and adjust your treatment intervention to the level of emotions and the needs of the group. When appropriate, you can introduce the SUD measure to track change. This stimulates interest and curiosity about the outcome of the treatment process. By learning to assess and record the SUD level for the aspect being addressed after each treatment cycle, the focus of treatment can be returned to later in the process if it changes before the aspect is fully healed (i.e., a SUD rating of 0 is obtained). In this way, the mental health worker can honor the client's experience and tailor the treatment to the needs of the client or group in order to provide thorough treatment.

THE TREATMENT METHOD

Affirmation

An affirmation is a self-empowering statement that precedes one's stated acceptance of the emotions associated with the issue or aspect. The statement strengthens the client's self-acceptance and is used to correct most barriers for healing (Flint, 2001, p. 20). When reciting the chosen affirmation, the client should press hard enough to find a sore spot on his/her chest, about 3 inches down and 3 inches over from the notch in the neck (see Figure 1). The sore spot is then rubbed continu-

FIGURE 1. Locating a Sore Spot



ously while the client repeats the phrase: "I accept myself even though I have this [*insert reminder phrase*]" three times. Other affirmations that can be used are as follows: (a) "I'm OK even if [*insert reminder phrase*]"; (b) "I deeply and profoundly accept myself even if [*insert reminder phrase*]"; or (c) "I love and accept myself even if [*insert reminder phrase*]" (Flint, 2001, p. 20). The reminder phrase is also said aloud when tapping on the acupressure points.

Modified Affirmation

The modified affirmation is used after the first treatment and when the SUD level stops reducing in intensity (Flint, 2001, p. 22). In this case, the affirmation is modified slightly by including words that emphasize the continuing intensity of an issue. When the SUD level stops going down, a barrier is believed to be stopping the healing process. When this happens, the client should do the entire treatment again, including the modified affirmation. The modified affirmation is also recited three times while rubbing on the sore spot on the chest, and includes statements such as: "I accept myself even though I **still** have some of this **remaining** [*reminder phrase*]." The words in bold are the important words to include and emphasize in the modified affirmation. Again, the client says the "**remaining** [*reminder phrase*]" aloud when tapping on the acupressure points.

The Acupressure Point Sequence

The acupressure point sequence consists of tapping five to seven times on each of twelve acupressure meridian points (Flint, 2001, p. 25). The tapping should be firm enough to hear the tap, but not firm enough to hurt. The client taps with the index and middle finger of each hand and simultaneously repeats a reminder phrase aloud to remind one of the content or emotion associated with the issue or aspect of the issue being treated. The 9-gamut sequence, described later, is done after the acupressure point sequence. This sequence is also tapped. Once it is completed, the acupressure point sequence is tapped again.

The twelve acupressure meridian points of the acupressure point sequence are as follows:

1. *Eyebrow*–Guide the client to locate both spots at the beginning of the eyebrow near the bridge of the nose (see Figure 2). Use both

hands to tap on both sides. Be sure the tapping spots are near the bridge of the nose. Have the client tap 5 to 7 times on those spots.

2. *Outer Eye*–Have the client locate the spot on the bone next to the outside corner of the eye (see Figure 3). Make sure the client taps on the spot adjacent to the corner of the eye. Tap 5 to 7 times on those spots on the bone with both hands.
3. *Under the Eye*–Locate the spot on the bone under the eye, directly below the pupil (see Figure 4). Guide the client to locate the right spots. Tap on those spots 5 to 7 times using both hands.
4. *Under the Nose*–Have the client find the spot under the nose (see Figure 5) and tap on it with the index and middle fingers using only one hand.
5. *Under the Lip*–Have the client find the spot under the lower lip on the indent area of the chin (see Figure 5) and tap. Again, use one hand.
6. *Collarbone*–This point may be a little more difficult to find. Have the client locate the notch at the top of the chest bone, at the base of the throat (see Figure 6). Have her put their fingers there and move them down 1 inch and, then, over 1 inch on the right and left sides of her chest. Be sure her fingers are only 2 inches apart. These are the collarbone spots. They are located on a depression under the joint of each collarbone. Have her tap on these spots with both hands.
7. *Under the Arm*–Now the client will tap on a spot 4 inches under the underarms (see Figure 7). For a woman, this spot is found on the bra material over the ribs. For a man, this spot is level with the nipple. They can cross their arms over the body to tap with their fingers or raise their arms and tap with their thumbs. Tap 5 to 7 times.

   Next, the client will be asked to tap on four fingers and on the edge of her left hand, one spot at a time. Instruct the client to tap 5 to 7 times on each spot. Figure 8 depicts the index finger of the left hand facing down so the client can clearly identify the location of the base of the fingernail. The client will be tapping on her fingers next to the base of the fingernail on the inside of each finger on the spot closest to her body. Have her carefully look at the pictures of the left-hand fingers, palm facing down, and follow the instructions. Incidentally, one can tap with either hand.
8. *Thumb*–Have her find the spot on the inside of the thumb closest to the body (see Figure 9). Then have her tap on the skin next to the base of the thumbnail.

9. *Index Finger*–Have her find the spot on the inside of the index finger. The spot is on the skin next to the base of the fingernail on the same side of the thumb (see Figure 10). Have her tap.
10. *Middle Finger*–Have her find the spot on the inside of the middle finger on the skin next to the base of the fingernail (see Figure 11). Have her tap. After tapping, skip the ring finger and go to the little finger.
11. *Little Finger*–Have her find the spot on the inside of the little finger on the skin next to the base of the fingernail (see Figure 12). Again, have her tap.
12. *Karate Chop*–Help her locate the spot on center of the soft skin on the outside edge of her left hand between the knuckle of the little finger and the knuckle of the wrist (see Figure 13). Have her tap this spot 5 to 7 times.

FIGURE 2. The Eyebrow

FIGURE 3. The Outer Eye

FIGURE 4. Under the Eye

FIGURE 5. Under the Nose and Lip

FIGURE 6. The Collarbone

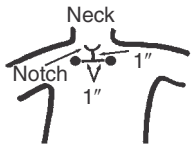


FIGURE 7. Under the Arm

FIGURE 8. Locating the Base of the Fingernail

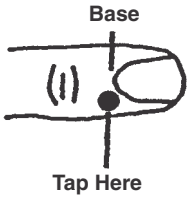


FIGURE 9. The Thumb

FIGURE 10. The Index Finger

FIGURE 11. The Middle Finger

The 9-Gamut Tapping Sequence

The 9-Gamut (Flint, 2001, p. 30) involves tapping rapidly on the back of the hand while following nine instructions (below). It takes some practice because the activity is like patting your head and rubbing your stomach at the same time. First, have the client find the spot on the back of either hand that is half an inch back from the knuckles of both the ring finger and little finger (see Figure 14) and tap rapidly on that spot while following the instructions described below.

While the client taps the back of the hand rapidly, have the client hold his or her head upright and do the following nine steps (Figures 15-23).

The 9-Gamut should be practiced until it can be done easily. To assist the client in learning EFT, the help sheet can be obtained online from http://www.emotional-freedom.com/files/helpsheet.pdf or http://www.emotional-freedom.com/helpsheet.htm.

FIGURE 12. The Little Finger

FIGURE 13. The Karate Chop

FIGURE 14. Locating the Spot on the Back of the Hand

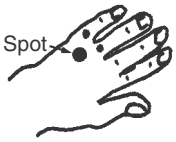


FIGURE 15. Close Eyes

FIGURE 16. Open Eyes

FIGURE 17. Looking Down to the Left

FIGURE 18. Looking Down to the Right

FIGURE 19. Circle the Eyes One Way

FIGURE 20. Circle the Eyes the Other Way

FIGURE 21. Humming Out Loud

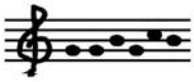


FIGURE 22. Counting from 1 to 5

Say: “1, 2, 3, 4, 5”

FIGURE 23. Humming Out Loud Again

A SUMMARY OF THE WHOLE INTERVENTION

To use the EFT treatment intervention with groups or individuals, the recipient(s) must be both prepared for the method and guided through the treatment process. To prepare one for EFT, the mental health worker helps the client to choose an issue, identify the important aspects of that issue, and develop reminder phrases for each of the aspects identified. In addition, preparation for this treatment method involves familiarizing one with the acupressure point sequence and 9-Gamut sequence that will be used during the course of the treatment process. In the preparation phase, the mental health worker helps the recipient(s) to do the following: (a) Identify the most bothersome target issue; (b) Inquire about other aspects of the issue that may be relevant; (c) List the aspects from least intense to the most intense; and (d) Obtain reminder phrases that are clearly related to the issues and aspects.

EFT treatment requires the client to tap on the acupressure points. It involves having the client cycle the EFT process for each aspect of the issue until the SUD level reported for each is reduced to 0 or close to 0. When using EFT with individuals or groups, the mental health provider must guide the recipient(s) through a series of steps, listed in Table 2.

TROUBLESHOOTING BARRIERS TO HEALING

If the SUD level stops decreasing, the client has hit a barrier to progress. Several examples of barriers are traumatic aspects, oppositional beliefs, a physiological condition that stops learning, dehydration, or the presence of an odor in the environment. All of these will stop the treatment process. There are several ways to remove a barrier blocking the treatment process (Flint, 2001, p. 38). To troubleshoot, the mental health worker instructs the client to try each of a number of commonly used corrections, in the order presented below, until they find the one that removes the barrier. Removal of the barrier is indicated by a decrease in the SUD level. The six most frequently used corrections to treatment barriers in EFT, which have been listed according to their likelihood of being utilized in disaster applications, are listed below (see Flint, 2001, p. 38, for the entire list).

1. *Modified Affirmation*. If the modified affirmation was not said, have the client do the method again and include the modified affirmation. The affirmation is the first part of the method and is specifi-

cally used to correct barriers that frequently inhibit progress. Sometimes, it may be necessary to use the modified affirmation with every application of the treatment cycle. In some cases, the emotional intensity measure will go down only one SUD level at a time.

2. *Review the Issue*. If the issue being focused on has a number of aspects, attempting to obtain therapeutic gains by focusing on only one aspect of the issue may not work. Therefore, other aspects related to the issue may need to be addressed individually. Often the client may need to get more specific when describing an issue in order to assure that all of the important aspects are addressed. For example, with the issue "survived the forest fire," the aspects may be "fear of death," "fear of suffocating," "death of my cat," etc. Each of these aspects may contribute to the client's distress over the forest fire.

3. *A Brain Condition*. A form of brain disorganization is allegedly caused by neurological disorganization in the brain that prevents the change process (Durlacher, 1995, p. 48). As strange as it seems, by placing the back of the hand on the chest (see Figure 24) and then by tapping on the palm five times, this barrier is corrected (Flint, 2001, p. 40). Sometimes, if change is very slow, doing this correction before the modified affirmation causes more rapid change.

4. *Drink Water*. Sometimes our electrolyte balance is poor. Have the client drink eight ounces of water and try the method again.

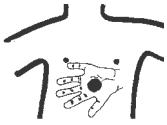
5. *Change Location*. Environmental factors, such as the smell of perfume or industrial solvents, may cause brain disorganization and stop the treatment process (Flint, 2001, p. 41). Having the client move to another location, such as the kitchen, the bathroom, outside, or elsewhere to try the method moves the client away from the chemical causing the barrier. If trying the method in another place works, then some chemical or property of the environment may have been causing the barrier. Taking a shower without soap may also correct this kind of barrier at times (Craig & Fowlie, 1995, p. 129).

6. *Patience and Persistence*. Some issues require the client to keep repeating the EFT treatment cycle several times per day. Having patience and being persistent by continuing the treatment on a routine basis over days may be necessary for success, particularly with recurring symptoms. Patience and persistence are required to complete the troubleshooting process, as well.

TABLE 2. Sequence of Steps of EFT

1. Unless contraindicated, have the client select the most bothersome issue or aspect.
2. Assess the starting SUD level of the emotions associated with the aspect.
3. While the client is rubbing the sore spot on her chest, she says the affirmation out loud 3 times.
4. The client then does the sequence. Have her tap on each acupressure point 5-7 times, repeating the reminder phrase out loud for each acupressure point.
5. The client is instructed to think of the reminder phrase and do the entire 9-Gamut treatment.
6. Then have the client repeat the sequence by tapping on each acupressure point 5-7 times, repeating the reminder phrase out loud for each point.
7. Reassess the SUD level of the emotions attached to the aspect.
8. If the SUD level drops more than 2 points, have the client repeat the treatment cycle. If the SUD level stops going down, have the client use a modified affirmation as described above, and repeat the whole EFT treatment cycle 1 to 7. If it still does not decrease, the mental health worker will troubleshoot with the client.

FIGURE 24. Location of Tapping Correction for a Brain Condition



USING EFT IN A DISASTER SITUATION

Immediately after a traumatic event, most survivors need additional emotional and cognitive resources to manage their experience. The contribution a mental health worker offers is a secure relationship with clients. This relationship allows the clients both to reorient themselves in the face of the events and deal with practical issues such as accessing money, telephoning relatives, and dealing with household pets. The sur-

vivors' needs should direct the nature of the support and interventions offered during this time. Such logistical and emotional support can help clients regain the resources needed to cope with a traumatic experience.

When survivors have reached a more or less stable state, they can be asked individually or in a group to tell their stories. At this point, the mental health worker can get information about the symptoms related to re-experiencing, avoidance, and heightened arousal that may emerge following a trauma. Examples of this information might be a verbal statement, a change in color, tearing, or a change in the vocal quality, like a shaky voice or a voice driven by painful emotion. Any of these examples would indicate that person was still distressed by the trauma and needed further attention. Groups and individuals are handled somewhat differently.

Working with Groups

When the expression of painful emotions has subsided and the attendees are less disorganized, a CISD group meeting can be held. CISD is not considered to be therapy, but is a part of the Critical Incident Stress Management process. It is a method used to help people process normal reactions to abnormal events. However, not all survivors should be put in the same group; it is important that those within a group have had a similar experience of the trauma. For example, those who witnessed a murder, those who heard the shots and saw the dead body or bodies, and those who were somewhere else in the building should be placed in separate CISD groups to avoid further traumatizing survivors with explicit details of the event that they did not experience personally. Similarly, the mental health worker should identify early in the process any clients who would rather be seen privately or who would benefit from being treated separately.

The CISD cognitive debriefing process encourages each member to express what he or she saw, heard, felt, smelled, tasted, thought, and did. For many clients, symptoms will be relieved in the course of the debriefing process. Some, however, will need further therapeutic support (e.g., individual psychotherapy or participation in an ongoing support group) to process the event. Social support facilitates processing, while therapist intrusion, irritability, and helplessness may inhibit it (Freedman & Shalev, 2000, p. 250). Several pretrauma variables have been shown to predict PTSD, such as child abuse, physical abuse, intelligence, and socioeconomic status (Freedman & Shalev, 2000, p. 250).

Therefore, while the goal of CISD is to stay focused on the presenting trauma, sometimes the processing of earlier material is unavoidable.

Using SUD measures to keep track of survivors' emotional distress during the debriefing progress adds to the CISD process. In addition, it is by the use of SUD levels that the mental health worker can introduce EFT as an adjunct to the CISD or individual debriefing process. The SUD measure should be defined early in the session and, using the approach described above, SUD ratings for various aspects of the trauma should be obtained both early in the session and a number of times throughout the CISD process. In addition, it is important for the mental health worker to be aware of the presenting problems that were precipitated by the traumatic event and to address specific incidents or emotions in order to track change and recognize when the symptom's intensity has been reduced or resolved. If, during the CISD process, survivors have had the opportunity to build a working relationship with the mental health worker and share their experiences, the movement between SUD levels will usually indicate a reduction in the stress connected to the event. A visible sign of symptom reduction (i.e., reduction in the SUD ratings) not only generates and maintains the group's interest in the process, but also provides the mental health worker with an opening to reveal the option to use EFT.

If the mental health worker has established solid rapport with the group, s/he can effectively introduce EFT to survivors at the end of the formal CISD as a method for further symptom reduction. The group should be asked if any of its members have experience with EFT and, if applicable, whether their experience was positive. At this stage (e.g., the second or third meeting in the "Utrecht" model [Kleber & Brom, 1992, p. 94]), EFT can be introduced as an additional technique to help the client overcome the trauma by further reducing the SUD level associated with various aspects of it, without the in-depth re-experiencing of the event. Before using EFT, the clients must feel safe within the context of the relationship with the practitioner and the group. By the end of the process, the group may be ready to accept EFT as a gentle method to lower any remaining emotional intensity levels. If so, practitioners should specifically ask what symptom is still intense and focus their use of the EFT treatment to the identified area of concern.

Working with Individuals

When working with individual trauma survivors, distress about the various aspects of the traumatic event should first be measured in terms

of SUD levels. Once rapport has been established, EFT can be introduced as a process to reduce emotional pain or as a means of lowering their ratings on the SUD scale. The mental health worker should listen for painful experiences, memories, pictures, or sounds associated with the traumatic event. Determine whether or not the client has negative or maladaptive beliefs, flashbacks, or auditory, visual, or olfactory intrusions. These internal events are caused by trauma and will need treatment. With each issue, look for other beliefs or associated aspects that are related to the issue. The aspect that is most bothersome to the client should be selected for EFT treatment. Once resolved, the remaining aspects can be systematically treated in order of the level of distress they are causing.

When the experience unfolds in a sequence of traumas, in some cases it may be appropriate to heal from the most recent trauma in the sequence and then work backwards to the first trauma of the sequence. This is done for several reasons. The most recent trauma is usually less threatening than the initial trauma. The initial trauma often has happened at a time when coping skills were not yet fully developed because of lack of life experience. If the treatment begins with the first trauma of the sequence, the later traumas may be triggered resulting in emotional flooding. Also, if the last traumatic experience is not the worst and is addressed first, the client can learn that the trauma of an event can be resolved.

After a number of rounds of EFT, the client will be ready to tell the "story" of the traumatic incident. If the client can tell the story from beginning to end without any distress, treatment can be considered complete. If, however, the client experiences any residual emotional distress as s/he reports the details, continuation of the EFT treatment is indicated for the aspects of the story that are causing the emotional experience.

In ongoing crisis situations, if acceptable to the client, EFT can be used to stabilize the client's flood of emotions, as well as to process aspects of the traumatic events. In situations where the threat of disaster is ongoing or pending, the use of EFT can help the client to think more rationally and protect themselves better. For example, EFT is effective with either individual or group treatment in situations or countries with ongoing violence (P. Cane, personal communication, April 16, 2002).

CASE STUDIES

Case 1

A therapist was asked to conduct a Critical Incident Stress Debriefing (CISD) for 35 members of an organization where an employee had died (Mitnick, 1998). The formal CISD session was 90-minutes long. During the session, the therapist continually assessed if EFT would be an appropriate intervention. After the therapist introduced herself, she set the ground rules for the session and described the seven-step CISD process. She also set the stage for the possibility of using EFT by telling the participants that, if they experienced any emotional distress, she could teach them a method that would provide quick relaxation and would most likely diminish the intensity of their distress. The SUD scale was explained and initial scores were obtained after the explanation. Group distribution of SUD scores indicated a few participants at 8-9, most at 5-6, and a few at 3-4. SUD level reassessment was done after each of the seven steps in the CISD process and levels of intensity diminished for most participants at each step. This process of self-evaluation kept participants in close touch with their emotions, clearly revealed their progress, and reminded them of their options for further support. Most participants in the formal CISD had significantly lower scores (SUDS ranging from 3 to 0) by the end of that session.

Six participants asked for additional individual EFT assistance and found rapid relief by using this method. Following the CISD session, the six participants who requested EFT formed a small group. These participants were still feeling intense about the death during the formal CISD, but after the tapping of EFT in the small group setting, they had significantly reduced SUDS to between 2 and 0. The EFT session was very brief and only one or two aspects were dealt with for each participant. Of course, everyone had a slightly different experience of the trauma since they all came from different life experiences, but as a group, their relationship with the deceased was the same. EFT was, for them, an appropriate intervention for more completely reducing and eliminating traumatic memories after a formal CISD session.

Case 2

The second author treated a client who was traumatized from an accident that occurred while working on a moving train. While the crew tried to connect a line of railway cars to a single stationary car at the end

of the track, a coworker was riding on the last moving car. The client was receiving instructions from this coworker by means of a short wave radio when he suddenly heard, via the radio, the voice of his colleague exclaiming: "They got me!" The train had been moving too fast and the car on which his colleague was riding collided with the stationary car. His colleague was severely injured and lost his foot.

Six years later, the client still experienced intrusions of the voice of his coworker and still experienced significant guilt about his coworker's injury. Twenty minutes of CISD processing was spent on the accident. This reduced the SUD level for the intrusion of the memories of his coworker's voice from an 8 to 4. The CISD process also helped the client to build a working relationship by showing the client that the practitioner believed him and took him seriously. This made it relatively easy to introduce and use EFT. After processing the trauma with EFT, the client's SUD score dropped to zero after only a few treatments. Following treatment, the client's guilt was also considerably reduced and he could see that it was his colleague, not he, who had made the mistake.

Eight months after he received treatment during an EFT training for railway relief workers, the client wrote that he has asked himself repeatedly what he was so troubled about during those six years. He added that there are no symptoms connected to the event now, and he was able to tell the story without negative emotions or bodily symptoms. In his "mind's eye," it was as if the memory of the situation had dissolved.

RECOMMENDATIONS FOR FUTURE STUDY

The following research could be done to enhance the use of EFT in disaster situations. Though it is inappropriate to use disaster survivors directly as identified experimental subjects in a research project, practitioners can obtain helpful data by developing and gathering data on a Case Results Form. The Case Results Form would obtain feedback as to how the CISD and EFT processes were introduced, how the group accepted the interventions, how the issues and aspects were identified, and how successful the CISD and EFT interventions were. Access to such forms would also allow researchers to compile a list of problematic issues typically facing disaster survivors. This data would increase our understanding of how to use EFT in disaster settings and would be helpful in creating an EFT treatment protocol based on data for using of EFT in complex disaster situations. For additional information concerning the use of EFT, please see the resources provided in the Appendix.

Author Note

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APPENDIX
Reading List

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