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Clinical EFT (Emotional Freedom Techniques) as Single Session Therapy: Cases, Research, Indications, and Cautions

Abstract

Clinical EFT (Emotion Freedom Techniques) is an evidence-based practice that combines elements of exposure and cognitive therapies with the manual stimulation of acupuncture points. The research literature indicates it to be efficacious for a number of psychological conditions in a variety of treatment time frames. Randomized controlled trials demonstrate that EFT effectively treats phobias and certain anxiety disorders in one session. A single session also results in a significant drop in cortisol and normalization of the EEG frequencies associated with stress. EFT has the client focus on specific traumatic memories; the emotional intensity of these memories usually diminishes rapidly during treatment. This makes EFT an efficient single-session treatment for emotional distress associated with episodic memories. For conditions such as complex co-morbid PTSD, combination treatments and longer courses are indicated, though even treatment-resistant clients often experience some relief after a single session. Psychological symptoms of PTSD, depression, and anxiety typically reduce simultaneously, along with physical

symptoms such as pain and insomnia. Clinical EFT also offers a suite of techniques developed to address treatment barriers such as dissociation and overwhelming emotion. This review and case series examines the conditions for which a brief course of EFT treatment is appropriate, when it is not indicated, when it can be taught to the client as a form of self-care, and when professional administration is required. It also cautions against generalizing EFTs rapid efficacy for certain conditions; this may contribute to unreasonable expectations in therapist or client. EFT is recommended as a front line primary care intervention to improve mental health and physical symptoms.

Keywords: PTSD, phobias, depression, anxiety, cortisol, psychotherapy, primary care, EFT (Emotional Freedom Techniques).

Introduction

One of the best-known single-session case histories in the field of energy psychology was described by psychologist Roger Callahan (2013). A client he calls “Mary” had a longstanding phobia of water. Her parents reported that she had exhibited a marked phobic response to water since infancy. Now in her 40s, she was still frightened every time it rained. She could not take baths in a tub full of water. Though she lived near the ocean, the mere sight of it caused her so much anxiety that she never visited the beach. She had frequent nightmares of being engulfed by water. Callahan worked with Mary using conventional techniques for 18 months but made little progress. He had a swimming pool near his home office, which he used to test her phobic reaction. The best result he had been able to obtain was having her sit on the edge of the pool and dangle her legs in the water, though even this degree of proximity triggered marked anxiety.

Mary had told Callahan that when she thought of water, she had a sick feeling in the pit of her stomach. Callahan had recently learned about acupuncture points and meridians, and knew that the end point of the stomach meridian was located under the pupil of the eyes. During one session, “not expecting much of anything to happen,” Callahan suggested she use her fingertips to tap under her eyes. She did so, and exclaimed that the feeling in her stomach had vanished. She leaped from her chair and ran to the pool. Her fear of water had vanished. The nightmares ceased, and when followed up almost thirty years later, Mary’s water phobia had not reappeared.

This experience led Callahan to experiment with a variety of acupressure points for a variety of psychological conditions, and publish his findings (Callahan, 1985). Manual stimulation of acupuncture points is called acupressure, and is used in a variety of therapies such as Shiatsu massage as an alternative to the insertion of acupuncture needles. A randomized controlled trial showed pressure on the points (acupressure) to be as effective as needling (Cherkin, Sherman, & Avins, 2009). Callahan first learned about manual acupoint stimulation from John Diamond, a chiropractor who developed a technique called Applied Kinesiology (Diamond, 1985). Callahan developed an extensive set of diagnostic and treatment techniques which he called Thought Field Therapy (TFT; Callahan, 2000). The acupoints tapped were usually on the endpoints of acupuncture meridians as identified in traditional Oriental medicine (Gallo, 1999).

Oriental medicine identifies 14 of these meridians, which are believed to be conduits along which energy flows in the body. Modern equipment has allowed investigators to detect electromagnetic differences between acupuncture points and the surrounding skin (Syldona & Rein, 1999). Investigators using fluorescent nanoparticles

have traced the paths of tiny threadlike structures called Bonghan Ducts running through acupuncture meridian pathways (Jhong et al., 2007). Acupuncture points have an electromagnetic resistance much lower than that of the surrounding skin, and may easily be found by a practitioner using a hand-held galvanometer. TFT has practitioners first diagnose which meridians to treat, then has them tap on a series of points prescribed for that particular condition (Callahan, 2000).

One of Callahan's students, an engineer and performance coach named Gary Craig, then simplified TFT and called his version Emotional Freedom Techniques or EFT (Craig & Fowlie, 1994). He discarded TFTs lengthy diagnostic protocols, reasoning that since there are only 14 meridians, and each one takes only a few seconds to tap, a complete round of acupoint stimulation can be completed in less than a minute. Unlike Callahan, Craig did not believe that the order in which the points were tapped was essential to effective treatment. EFT and TFT also use elements of exposure therapy and cognitive therapy, combining these with acupoint tapping (Feinstein, 2012). Cognitive and exposure therapies were identified as effective treatments for PTSD in a review by the US government's Institute of Medicine (Institute of Medicine, 2007). Acupuncture has also been used successfully to treat PTSD (Zhang, Feng, Xie, Xu, & Chen, 2011). The acupoint tapping component of EFT has been shown to be an active ingredient in treatment, and not merely a placebo (Fox, 2013). There are many methods similar to TFT and EFT, as well as variants of both; Gallo (1999) coined the term "energy psychology" to describe this class of therapies.

A robust research base has emerged to support both EFT and TFT, with Feinstein (2012) identifying 51 clinical trials of the two methods. Feinstein (2012) compares the research with the standards for “empirically validated treatments” published by Division 12 (Clinical Psychology) of the American Psychological Association (APA), and finds that they meet criteria as an evidence-based practice for anxiety, depression, phobias, and PTSD.

As outcome studies have demonstrated efficacy for energy psychology, investigators have turned their attention to the underlying physiological mechanisms of action involved. A large triple-blind randomized controlled trial investigated the role of the stress hormone cortisol in treatment (Church, Yount, & Brooks, 2012). In this study, one group received a single hour-long EFT session. A second group received an hour of conventional talk therapy in the form of a supportive interview. A third group simply rested. Psychological symptoms were assessed using a valid and reliable instrument called the Symptom Assessment 45 (SA-45; Davison, 1997). The SA-45 has two global scales for the breadth and depth of psychological conditions, as well as nine subscales measuring specific conditions such as anxiety and depression. Clients are asked to respond to the 45 items based on their experience over the prior 7 days.

Analysis revealed that overall symptoms declined by more than twice as much in the EFT group as in the other two groups ($p < .001$), and a significant drop of 24% in cortisol was measured ($p < .03$). EFT thus produced both psychological and physiological change. The degree of psychological change in a single session was significantly correlated with the drop in stress hormones.

Hormones such as cortisol are one part of the body's physiological response to stress. It can also be assessed in the autonomic nervous system and brain using measures like EEG, EMG, heart rate variability, and galvanic skin response. Paralleling the results of the cortisol trial, studies using EEG find reductions in the brain wave frequencies associated with stress after an energy psychology treatment (Swingle, Pulos, & Swingle, 2003; Lambrou, Pratt, & Chevalier, 2005; Swingle, 2010).

Case History 1: Grief and Cortisol

I performed a second cortisol test with one of the participants in the cortisol study. The subject, a 58 year-old male psychiatric nurse, was randomized to the supportive interview group. His indicators of psychological distress were as high after the interview as before, unlike other members of the group, who experienced a modest decline.

In the second treatment session, performed outside of the main study, I used EFT. I selected this participant because I was curious whether his scores on the SA-45 would change after EFT as they had not done after talk therapy. The way EFT was administered was typical of the standardized protocol described in *The EFT Manual* (Craig & Fowlie, 1995). This consistent and manualized form of EFT has been used in research, and is termed Clinical EFT (Church, 2013). I scheduled this session as close to the same time of day as the first session as possible, because cortisol rises and falls in a stable diurnal rhythm. For best results, cortisol assays must be administered at chronologically synchronous intervals. The supportive interview began at noon, while the EFT session began at 10 am.

A Clinical EFT session usually begins by having the client focus on a particular event with a high degree of emotional charge. For this client, the triggering event

occurred when he was 5 years old. He saw a television advertisement in which Gina Lolo brigida was touted as “the most beautiful woman in the world.” After watching the advertisement, he went to the bathroom, climbed up onto a stool, and looked at himself in the mirror. He concluded that he was not good looking, and realized he never would be. His somatic experience as he described the memory was a pain in his solar plexus, which he assessed as a 3 out of 10 intensity.

Clinical EFT uses a scale called SUD or Subjective Units of Distress, first popularized by Wolpe (1973). This 11 point Likert scale has clients rate their distress on a continuum from 0 (no distress) to 10 (maximum distress). Clinical EFT practitioners typically ask the client for a SUD score when remembering a traumatic emotional event, and again after treatment. In this way, client progress is self-rated.

The client’s second memory was working on the assembly line at Bendix Brake corporation at the age of 20. He could not assemble the parts fast enough, and he was fired. His SUD around this incident was a 2. He had now provided me with two specific memories, which though he remembered them as highly emotional, he scored at a low level on the SUD scale. This suggested to me that the client might have a pattern of dissociating from troubling emotions. He appeared to be “in his head,” approaching troubling incidents by way of mental evaluation rather than actually feeling them.

He then said that every day he thinks about the million unborn babies that will be born into a life of suffering. He felt “deep sadness, anger at myself, depression” accompanying these ideations. His SUD intensity was a 3.

Finally he described a breakup with a girlfriend. He stated that he thinks about this breakup every day. He said that on the final day of their contact, he drove his girlfriend to

the airport and put her on an airplane to the opposite coast where she was moving. The fragment that was most emotionally poignant to him was where she looked back as walked up the jetway “with stunned regret.” Yet his SUD intensity remained low, self-reported as a 3.

In an attempt to induce the client to get in touch with his feelings, I probed for additional details of the event, such as his girlfriend’s physical appearance, and the last words she said. His SUD then rose to a 6, and he became tearful and red-faced. He described his feelings as a “soggy sponge” with the locus being, again, the solar plexus. Given the intensity of his feelings I assumed that the breakup was recent, but inquiry revealed that it occurred 8 years previously. Yet he could clearly remember the details, and shifted to describing the event in the present tense rather than in the past tense. Ruden (2005) notes that traumatic events are often “frozen in time,” with all the sensory channels, sight, sound, smell, taste and touch, encapsulated in that present moment rather than being integrated into the psyche as part of the past.

After tapping on Gina Lolobrigida incident, we reassessed his intensity around the other incidents as well as that one. The mirror incident had decreased to a 0. The Bendix assembly line remained at a 2. The “million unborn babies” thought diminished to a 1. The breakup incident diminished to a 1, as assessed by the intensity of the feeling in his solar plexus. After the session, I had him fill out a second SA-45, and administered a second cortisol assay.

When presented with the clipboard to which the SA-45 was attached and asked to fill it out, the client said, “This is ridiculous. This is asking me about the last 7 days. How can I have changed in an hour?” He proceeded to write down the exact same scores as he

had provided on pretest. He remembered his earlier scores, and duplicated them precisely on the second assessment.

In my experience of administering well over 1,000 SA-45s in numerous studies, this response by a client is highly unusual. Even though the SA-45 instructions tell the client to recall the previous week, scores usually drop after a single EFT session. The events may be the same, but the cognitive frame through which the client views them may be very different, as we will see in subsequent case histories presented here. Objective reality might not have changed, but when subjective reality changes a reduction in psychological symptoms can result.

When the cortisol results arrived back from the lab (SabreLabs.com) a few days later, they showed that the subject's cortisol levels had dropped from 4.61 ng/ml to 2.42 ng/ml, or -48%. This was at the extreme low end of the range of cortisol reductions found in the EFT group as a whole. After his talk therapy session the subject's cortisol had risen from 2.16 ng/ml to 3.02 ng/ml, an increase of 40%.

The lesson for me in this case was that a practitioner receives messages from the client's mind, and messages from the body. They might not be congruent, especially with dissociative clients. This client showed no improvement in psychological scores, but a massive drop in cortisol. Psychological assessment alone would have led me to conclude that the EFT session was unsuccessful, or at best a modest success based on client-rated SUD. Physiological assessment showed that the client had experienced a large reduction in stress at the biological level, despite the interpretation of his mind.

A typical feature of this case is the reduction in SUD for all the client's emotionally troubling events. In EFT this is called the Generalization Effect (Church, 2013). Note that

in this session we did not work on any of the adult events, only on the single childhood event. Once the SUD for the childhood event went down, SUD for all the adult events reduced too.

Therapists hypothesize that the reason clients are bothered by adult events is that they resemble childhood events. These associations are usually unconscious, and often surprising, as shown by the following brief case report. Clinical EFT practitioners are trained to look for, and work on, early events. Experience has shown that tapping on adult events often results in temporary improvement, but only finding the roots of patterns of emotional triggering in childhood events results in permanent rehabilitation.

Case History 2: Performance Anxiety and Specific Events

Clients typically present with a general issue such as a phobia or performance anxiety. Clinical EFT cautions against working with such global issues, training practitioners instead to identify particular events. The reason for this directive is that global diagnoses usually originate in specific events. When emotional traumas are encoded in our brains, they're engraved in episodic memory in the brain's hippocampus as specific events. So while a client may present with a general issue such as performance anxiety, the issue did not start out as a general problem with performance anxiety. The performance anxiety arises out of an aggregation of specific events, and only after they'd all accumulated can we identify and name a general problem. The following case illustrates this pattern.

“Jeanette,” a woman in her early 20s was a participant at a Clinical EFT workshop, and volunteered for a demonstration session in front of the whole group. Her presenting issue was performance anxiety. She said she had no problem during a performance, but

felt “horrible anxiety” every day leading up to one. She had an actual performance coming up in 2 weeks, and I asked her for a SUD score as she imagined it. She reported a 10, and the physical location as a burning sensation in her chest.

I guided her into finding several events that had contributed to the problem by asking, “Tell me about one of the first times in your life you remember feeling that exact same sensation in your chest.” The first one Jeanette identified was performing solos in Music Tech class at the age of 11. “There was one girl who looked so smug,” Jeanette said. “Her name was Melanie, and she knew she was the best singer. She'd look at me while I was performing, and I knew her look meant ‘You know I'm the best.’”

“Was it only solos?” I asked. She said Yes, when they sang together as a group in choir, no one could hear the individual voices. But when they sang solos in Music Tech, all eyes were upon her. We performed several EFT sequences on the incident.

In another incident, Jeanette had to give a talk about her summer vacation in front of the class in first grade. She prepared for days in advance, and wrote careful notes. When the day arrived, she opened her back pack, only to discover that she'd left her notes at home. She was very nervous, and even though the speech went well, the event left a lasting emotional impression. We tapped on that event too, till she reported a SUD of 0.

Jeanette described another event around the age of 9. She'd been asked to sing in the church choir, and went to rehearsals to practice with the group. She enjoyed the singing and the companionship of the rehearsals, and eventually the great day dawned when they had to sing in front of the congregation. When they assembled in the choir room just before the service, the choir master discovered that most of the sets of music sheets were missing. So each group of 3 choir members had to share a sheet of music. Jeanette was

too far away from the friend holding the sheet to be able to see it properly, and felt under great stress, even though the performance went “fairly well.” We tapped on this final event.

When I asked Jeanette to characterize her anxiety now as she imagined her upcoming performance, her SUD score was a 0 out of 10. Note that we had not done EFT on her performance anxiety or the upcoming performance, only on individual childhood events that contributed to the presenting issue. Jeanette’s results are consistent with those of a randomized controlled trial of EFT for public speaking anxiety (Jones, Thornton, & Andrews, 2011). These investigators found that a single session of EFT was sufficient to address both behavioral and psychological blocks to public speaking.

A single EFT session can also make a significant difference in sports performance. A randomized controlled trial of soccer players found a significant improvement in free kick performance (Llewellyn-Edwards & Llewellyn-Edwards, 2012). A similar trial found that basketball players receiving a 15-minute EFT session scored 38% more free throws ($p < .05$) than a placebo control group (Church, 2009). A 20-minute EFT session was found to increase confidence and decrease anxiety in an uncontrolled study of female college-aged athletes (Church & Downs, 2012).

Case History 3: The Worst or the First, and the Apex Effect

While a client may seek therapeutic intervention for a general problem like performance anxiety, self-esteem, or procrastination, the roots of these problems are usually found in a sequence of specific events. For instance, a client with self-esteem problems might have self-talk such as, “I’m worthless. My needs don’t matter. I don’t amount to anything in the world.” These are global negative cognitions that arose from

traumatic events early in childhood. Each event may have been only a few seconds or a few minutes in duration, but collectively they influence the client. The client makes meaning of the event by locating it in a cognitive frame, such as, “My needs don’t matter.”

Clinical EFT training directs practitioners to search for the earliest events. There are usually many events, leading to the question of how to identify which ones should be the therapeutic target. A useful filter is the concept of finding “the worst or the first” event. One client I worked with in a group had been beaten often by his father when he was a child. I asked him to describe “the worst or the first” beating, and he described a particular beating that occurred when he was eight years old. His father hit him so hard that he broke the child’s jaw.

This particular client reported a SUD level of 10 when recalling this traumatic event. We worked on many aspects of the event, such as his father’s words, the expression on his father’s face, his father’s tone of voice, the circumstances surrounding the event (a birthday party with the client’s childhood friends). Once we had tapped on all the aspects of the event, the client’s SUD went down to 0.

Obtaining pre- and post SUD scores, as well as intermediate assessments, is vital to good EFT practice. The reason for this is that clients often forget how high their distress was before treatment. One veteran treated successfully for PTSD told his therapist after receiving six sessions of EFT that he wasn’t in bad shape and probably never had PTSD to begin with. She showed him his pre-treatment scores on the PTSD Checklist - Military (PCL-M; Weathers, Huska, & Keane, 1991). He was astonished at how high his scores had been prior to treatment. This therapist was one of a group of about 400 therapists

who treat veterans as part of a national organization called the Veterans Stress Project (StressProject.org). Many Veterans Stress Project therapists report similar cases. The phenomenon of clients forgetting the severity of their former problems is noted so frequently in EFT and TFT treatment that Callahan coined a term for it, the “Apex Effect” (Callahan, 2000). The neurological processes that underlie the Apex Effect are beyond the scope of this paper, but the Effect presents an argument for the importance to both client and practitioner of recording frequent SUD scores.

In the case of the client who had been beaten by his father, the drop in SUD for the specific event was reflected in a drop in SUD for the collective experience of being beaten. At the end of the session the client said, “My father did the best he could. He wasn’t very good at it, but he tried. And when he was a kid, his dad beat him far worse than he beat me.” This language indicated a cognitive shift in the client, from a position of helpless childhood victim to an adult perspective of reflection and assessment. This type of cognitive shift is typical of successful EFT treatment. Clinical EFT practitioners are trained to watch carefully for cognitive shifts in clients. A shift in the cognitive frame in which a client holds an event may be an indicator of treatment progress. Cognitive shifts are a method of testing the results of treatment that possess more nuance than the rudimentary yardstick of SUD.

The limbic system in the mammalian midbrain, and especially the hippocampus, has been developed in a long evolutionary cycle to make associations. Proximate sensory cues are compared to historical events in order to determine if they present a threat to survival. If the hippocampus finds a match between a new event and an old one, it signals the amygdala to initiate a full-fledged stress response (Phelps & LeDoux, 2005). Therapy

sessions that address current problems might provide some relief, but experience with EFT has shown that fast and permanent symptom change is usually accomplished by targeting old events.

When the soothing somatic input of acupuncture signals the hippocampus that no objective threat is present, even when the brain's prefrontal cortex is simultaneously presenting the limbic system with a troubling subjective memory, the association between the forebrain signal and the stress response may be broken for all similar memories. Once this conditioned response has been interrupted one time, the link is often permanently broken. The individual may have the same troubling emotional thought again, but it is no longer encoded by the hippocampus as an objective threat to survival. The hippocampus therefore does not signal the amygdala to initiate a systemic stress response even though the mental stimulus is present. Once the association has been broken for the most traumatic childhood memory, the hippocampus may generalize this counterconditioning to embrace all other memories with a similar emotional content. Clinical EFT makes use of this "generalization effect" so that the client does not have to work on every single memory.

The associations made by the hippocampus are often surprising to both practitioner and client, as the following case demonstrates.

Case History 4: Acrophobia and Hippocampal Associations

At an EFT workshop I worked with a retired gentleman on acrophobia. He said he hadn't been able to go near a balcony for years, and he avoided going to the city because he'd have to deal with high-rise buildings. He joked about friends saying things like, "let's go to the Transamerica tower and see the view from the observation deck." I asked him

when it was worst (“the worst or the first”), and he identified it as a building with floor to ceiling windows. The workshop was being held in a single floor building with no opportunity to test his SUD level *in vivo*, so I asked him to imagine in his mind’s eye walking up to a floor-to-ceiling window and tell me how closely he could get without stopping. He said he could get within 6 feet of the window and at which his SUD level was a 9, and the physical sensation was in his throat.

I asked him to identify the first time in his life he had felt the same physical feeling in his body. He said that when he was three years old that his family lived in a house near a mine. It was very noisy, and miners disappeared down a shaft everyday. He didn’t know why that experience was so emotionally troubling for him, but we tapped on it anyway. He then shifted to another event, when he was two years old, when his father started up his motorcycle in the driveway. It also made a loud and startling noise. As we tapped, the SUD on the motorcycle event went down to a 1, after which I tapped on as many aspects of the mine as he could recall.

At that point I tested our results by asking him to again imagine approaching a floor-to-ceiling window. He was able to walk all the way up to the window and his highest SUD level was a 2. He stated that felt as though he could now handle going to the city with its tall buildings.

Why did the client associate the sound of the mine with a fear of heights? Neither the client nor I could make the link with our conscious minds. Yet the client’s hippocampus did associate the two. One of the challenges in Clinical EFT practice is to avoid assumptions. Associations between disparate events may be hidden in surprising niches in the psyche, with physiological correlates in neural pathways in the

hippocampus. Only by listening very carefully, and respecting the client's reports, can they be identified and treated. Clinical EFT training emphasizes the importance of the therapist "getting out of the way" in order to allow insight to emerge organically from within the client's own psychological processes and neurological configuration.

Clients and practitioners have been recording case histories in an online database for over a decade, and amassed some 5,000 anecdotal accounts (EFTuniverse.com). Several hundred of these stories describe recovery from phobias. Besides this clinical evidence, EFTs efficacy for phobias has been demonstrated in three randomized controlled trials.

Three RCTs have examined the effects of EFT on phobias and found that a single session is usually enough to resolve a phobia (Wells, Polglase, Andrews, & Carrington, 2003; Baker & Siegel, 2010; Salas, Brooks, & Rowe, 2011). All three studies included a follow-up period and found that the phobic responses of participants remained significantly lower than before treatment. These studies show that EFT meets the standards of APAs Division 12 Task Force on Empirically Validated Treatments (Chambless & Hollon, 1998) as an effective single-session remedy for phobias.

In terms of treatment speed, I conceptualize phobias as one end of the spectrum of anxiety disorders, with PTSD at the other end. While there are very few accounts of a phobia requiring more than one EFT session, PTSD has been described as a "treatment-resistant" condition (Seal et al., 2010). Only a third of veterans referred to a comprehensive yearlong PTSD program at a Veterans Administration hospital completes the prescribed course of treatment (Seal et al., 2010).

EFT for PTSD

EFT has been evaluated in several studies of PTSD. Most of these use several treatment sessions, and a detailed discussion of these results is beyond the scope of this paper. However, there is one study of a single session of EFT for PTSD that is of interest, and it is helpful to locate this study within the body of research for this condition.

A hospital in Britain's National Health Service (NHS) conducted a study of EFT for PTSD in its patients (Karatzias et al, 2012). The NHS study compared EFT to Eye Movement Desensitization and Reprocessing (EMDR), and found that both remediated clinical PTSD levels in an average of four sessions. A randomized controlled trial of veterans with clinical levels of PTSD symptoms found that they could be successfully treated in six EFT sessions (Church et al., 2013). Pilot studies that preceded these randomized controlled trials shows similar results (Church, Geronilla, Dinter, & Brooks, 2009; Church, 2010). Outcome studies of traumatized populations such as Haitian earthquake victims (Gurret, Caufour, Palmer-Hoffman, & Church, 2012) and Congolese women (Nemiro, 2013) also demonstrate EFTs effectiveness for PTSD.

The population for the single-session study was drawn from a group of male adolescents in a group home (Church, Piña, Reategui, & Brooks, 2012). The boys in the institution had been committed its care by a judge because of physical or emotional abuse at home. This randomized controlled trial compared participants who received EFT to a control group receiving no treatment beyond that routinely offered by the institution. All participants scored in the "clinical" range on the Impact of Events Scale (IES: Horowitz, 1979). Each participant in the EFT group (n = 8) was asked to recall a specific traumatic incident ("the worst"). Thereafter, they received an hour-long comprehensive session from an experienced practitioner. Aspects of the experience, such as the physical

appearance of their abuser, the tone of voice, and physical sensations, were addressed. Participants received a posttest 30 days after treatment, and all participant symptoms scored in the “non-clinical” range ($p < .001$).

The Karazias et al. (2010) study found that an average of 4 sessions was required to remediate PTSD in hospital patients, a treatment time frame similar to the 6 sessions used with veterans in Church et al. (2013). Why did the Church et al. (2012) study of adolescents find that a single session might be sufficient? The reason may lie in the age differential between the populations. This is suggested by a randomized controlled trial of depression in which clinically depressed teenagers were given EFT group therapy (Church, De Asis, & Brooks, 2012). On follow-up, scores for the EFT group were in the “non-depressed” range of the Beck Depression Inventory (Beck, Steer, & Carbin, 1988). Hebb’s Law is simply expressed as “neurons that fire together, wire together,” and studies of PTSD show that it produces durable changes in the brain over time (Vasterling & Brewin, 2005). While neural plasticity is helpful when applied to positive stimulation such as learning new skills, it can work to our disadvantage when our brain repeatedly processes the signals of stress, such as the intrusive thoughts, flashbacks and nightmares typical of PTSD. Over time, parts of the brain responsible for cognitive function, and the conversion of short term to long-term memories, shrink in volume in PTSD patients (Vasterling & Brewin, 2005).

I also believe that practitioner training plays a part in such a quick outcome. I speak from the perspective of supervising a large group of Clinical EFT trainers, as well as having conducted many practitioner trainings myself. I read over a thousand case histories annually in the course of practitioner evaluation. This has led me to conclude

that a thorough knowledge of all 48 Clinical EFT techniques, as well as training in other psychotherapeutic methods, plus a diversity of clinical experience, leads to the best client outcomes. The veterans PTSD study (Church et al., 2013) used 14 practitioners with a variety of backgrounds and levels of training, while the adolescent male study (Church et al., 2010) used a single expert practitioner. While EFT is a useful way to reduce the emotional intensity of traumatic memories, much more is required for a client with complex PTSD and co-morbid conditions.

However, even a single session usually produces some results for PTSD patients. Church et al. (2013) used an intermediate assessment after three sessions, in addition the post treatment assessment after 6 sessions. The three session evaluation showed that symptoms of PTSD, depression, and anxiety were reduced, along with physical symptoms of insomnia, pain and traumatic brain injury (TBI). Anecdotally, veterans often reported some improvement after the first session. During the second session, several reported to their practitioners that they had experienced their first uninterrupted night's sleep since they returned from Vietnam. I now present some case histories of clients with PTSD drawn from the Church et al. (2013) study.

Case History 5: Vietnam Nurse and Allergies

Subject's body was so sensitive that she was unable to tolerate EFT tapping on any part of it without getting violently nauseous. Subject reported many incidents of physical abuse starting in early childhood, and was so physically sensitive that she was easily triggered by physical stimuli. She couldn't wear socks or shoes, and couldn't tolerate physical touch by others. Her companion, reporting that their life situation was "unbearable," and that she was "in complete desperation," arranged for coaching.

Subject's intolerance to touch presented a challenge to finding a way to let her apply EFT. She found that she was able to tolerate tapping between her eyebrows, so that was the only point used in the first session, which focused on fear and safety issues.

Half way through the second session, she noticed that she could now tap on every EFT point, including the collarbone point, which had previously been her most sensitive spot. During this and subsequent sessions, the client worked with three specific war memories, and two physical symptoms, among other issues. These five coaching targets are summarized below.

(1) Subject had rescued some Vietnamese village people, elderly and children and was treating them in her field hospital. A US Army sergeant came in and ordered her to discharge them immediately because the space was required to treat American service personnel. The subject outranked the sergeant, and refused. At that point, he withdrew his service revolver from its holster and put the barrel to her head. He said he was going to kill the villagers one way or the other, and her only choice was whether or not she was going to die first.

Realizing the rage he was in, she knew she had no choice, and rescuing the villagers was completely out of her control. She knew that the only thing she could do was to allow for them to go in peace and with dignity, with no fear or panic, in the tradition of their culture. To insulate them to the violence of the sergeant, she very gently pulled the IVs out of their arms, allowed the children to gather around the elders for support, and encouraged them to leave the hospital as a group. Once outside, they were shot by the sergeant.

The nurse never recovered emotionally from the experience. She blamed herself for being responsible for the killing. She continued to have nightmares about the incident even decades later.

During the EFT session, subject tapped on the separate scenes of this traumatic event. She began to feel a sense of connection with the villagers, and come to an understanding that they were actually grateful for her. They had witnessed the gun at her head and they knew that there was nothing more she could do. They didn't blame her but appreciated that she did the best she could. After this cognitive shift, the nightmares about the incident did not recur.

(2) The subject lives close to a military base. Helicopters frequently fly overhead, and she would go into involuntary panic at the sound. After several rounds of EFT, subject said that she now simply noticed the sound of the helicopters, without panic or agitation.

(3) One of the subject's most traumatic memories was of an incident in which the hospital she was working in was bombarded by friendly fire and collapsed on her. At the time the bombardment began, she had been walking down a corridor. Two children were present, and she grabbed them and threw herself over them, protecting them with her body while the hospital roof collapsed. She was the only person pulled out alive from the rubble. She spent many months in hospital and rehabilitation following the incident. She had frequent nightmares about the scene. After EFT, the memory no longer held emotional triggers. She was able to recount the incident calmly, without the emotional upheaval that she reported before.

(4) Subject had an allergic reaction whenever she consumed ice cream. She used EFT for the substance itself, and for her symptoms. Subject recounted that, in Vietnam, there were two things that wounded men requested: steak, and ice cream. Both were difficult to obtain, and represented the comforts of home. When subject would eat ice cream, she felt connected with the pain that she had witnessed. After EFT, the allergy subsided.

(5) Subject had a hearing impairment, due to scar tissue from various injuries. She identified shutting off her hearing as a defense mechanism, and repeated application of EFT was required. After EFT, her hearing improved to the point where she could hear the clicking of the keys on her computer keyboard.

Case History 6: Vietnam Combat Veteran

Subject had a violent, alcoholic father. He was drafted to serve in Vietnam. He worked on two specific memories, among others:

(1) The first night in Vietnam, he woke up horror, realizing he was in imminent danger, when an enemy artillery bombardment began at 2:30 am. The camp was completely unprepared, with plywood floors and no security, and the draftees had not yet been issued weapons with which to defend themselves. Their anger at the army for not being prepared for them and keeping them safe was enormous. The subject remembered drinking a bottle of scotch whiskey and smoking a pack of cigarettes the first night, while a friend of his, newly married, sobbed helplessly. The recruits slept uneasily under their beds. The artillery fire resumed every night at 2:30 am. Before the first EFT session, subject would wake up every morning at this time. After EFT, he was able to sleep through the night.

(2) Some of the workers in the camp were Vietnamese. They pretended to be friendly, but their families were connected to the enemy, and the subject discovered that they were secretly passing information about the base to the Vietcong. So he and the other recruits were never safe. Subject felt a sense of betrayal, and being unsafe, ever since, and was able to reduce his SUD score around these issues with EFT.

Other Combat Memory Examples

The following are examples of specific memories on which EFT reduced SUD scores to 0 during the course of a single session:

(1) An Iraq veteran described an incident in which the Humvee in which his best friend was the driver, hit an Improvised Explosive Device or IED, and was unable to extricate himself. He burned to death. The veteran used EFT for the incident. He then began to spontaneously recall the funerals of other people who had loved him. After reducing his SUD score for each one, he began to relax.

(2) Another Iraq veteran was the driver of a transport truck, and in charge of transporting the men inside safely. At night, he had a very limited field of vision through the vehicle's armor. The lack of peripheral vision made the drive very stressful for him. His passengers yelled at him for his inadequate driving, and he felt overwhelming anger for their resentment while he was so stressed, and trying to do a good job. He performed EFT for these memories, as well as for finding forgiveness, and tapped while imagining the other soldiers asking for forgiveness, using phrases like, "Sorry man for yelling at you. It wasn't personal," coupled with the EFT self-acceptance statement.

(3) A former Vietnam officer described ongoing threats from his subordinates. He described huge tension between white and black soldiers. He had stood up for a

Vietnamese woman who was about to be raped, and prevented the rape by his comrades. As a result, he was harassed by his compatriots for months.

One of his soldiers went into a rage after drinking heavily and pointed his rifle through the tent door at the soldier while he was asleep. The officer handcuffed his opponent outside the bar until he sobered up. From that moment on, the soldier tried to shoot the officer wherever his back was turned. The officer did not have a safe moment until the subordinate was killed in a firefight.

(4) Another Veteran shot a 9 year old girl who was pointing a rifle on him. He said, “I only saw the rifle! I was trained to shoot when somebody point a rifle at me! I found out later that it wasn’t loaded. She is always with me, smiling, and she never says a word. I have asked for forgiveness, I have asked my life to be taken for hers, but it hasn’t. I have to live with this memory every day, and I always see her. I wish I’d never come back from Vietnam.” The little girl was with him as a flashback for 44 years, quietly smiling at him. After EFT, she now disappeared. Most veterans report severe childhood trauma in addition to combat trauma. Issues include sexual abuse, parental alcoholism, physical abuse, poverty, and neglect. Some reported that releasing childhood trauma was more effective than releasing war memories in producing a reduction in emotional distress levels.

Limitations and Cautions in Using EFT

With a research psychologist colleague at the Psychology Department of the University of Arizona, I conducted an outcome study of healthcare workers (Church & Brooks, 2010). Participants were 216 healthcare professionals at 5 professional conferences. After a single day-long EFT workshop, their symptoms of psychological

conditions such as anxiety and depression declined by a mean of 45% ($p < .0001$). We found these results striking, since most of their gains were maintained on follow-up.

Before publishing these findings, after receiving the data analysis from my colleague, I interviewed a number of experienced EFT practitioners, seeking to understand the surprising magnitude of the symptom reductions noted. Their consensus was that such improvements were the norm with EFT, but that the results obtained during the first set of EFT sessions was not necessarily an indicator of what might be required for further improvement. The most superficial layer of psychological distress might yield readily to treatment, but the next and more highly conditioned layer might not. Early results can rarely be extrapolated out to the future.

Training in Clinical EFT stresses this limitation, and instructs practitioners against becoming overly enthusiastic after witnessing early results with EFT. Practitioner allegiance to the method can result in pressure on the client to live up to the practitioner's expectancy by reporting lower SUD scores. Practitioner training counters this tendency by emphasizing the importance of validating the client's experience, especially when SUD scores rise. A rise in scores is frequently encountered with dissociative clients, who might get in touch with their emotions for the first time in many years. Paradoxically, in these cases a rise in scores is an indicator of client progress. Practitioner neutrality and client validation is therefore a cornerstone of good EFT practice.

A phrase used in EFT to describe rapid treatment success is "one minute wonders." The EFT case history archive (EFTuniverse.com) contains hundreds of such stories detailing alleviation of psychological distress, as well a physical symptoms such as pain, swelling, headaches, and autoimmune diseases. However, practitioners who experience

one minute wonders can then develop the expectancy that every condition, psychological and physical, will respond as quickly. They soon discover that this is not the case. Some problems are multi-faced, complex, and treatment-resistant. Certain conditions, such as tinnitus, rarely respond to EFT treatment. Addictions are also often difficult to treat, with uncertain outcomes (Lake, 2013). While 86% of the veterans in the PTSD study (Church, et al., 2013) were subclinical after six sessions of EFT, 14% experienced no improvement. Like any other therapy, EFT is not a panacea.

EFT targets specific events held in episodic memory in the limbic system. Clients who cannot remember events for whatever reason present a challenge. When asked for an event that underlies their presenting condition, some clients respond with phrases like, “I can’t remember a single event,” or “I can’t feel anything in my body when I think of the event.” Clinical EFT has developed a number of techniques for such situations. The most commonly used one is drawn from TFT and is called the 9 Gamut procedure (Church & Marohn, 2013). It uses eye movements reminiscent of EMDR, and clients without memories, or without the ability to anchor emotion in physical sensation, usually report relief after using the 9 Gamut. While can be self-applied, it is complex, and execution is usually more successful with the help of a practitioner. Clients who cannot remember childhood events can find EFT challenging to use without expert professional support.

A different treatment challenge is presented by clients who experience overwhelming emotion. At one workshop I conducted, I talked to a middle-aged man who appeared very sad. He said, “I have so much grief, it feels like a huge reservoir. I have my finger in the dam. If I take my finger out and allow even a little bit of that grief to come out through the hole, the dam will burst and obliterate me.” Three EFT

techniques called the Gentle Techniques have been developed to accommodate such situations (Church & Marohn, 2013). They deliberately induce dissociation in order to give the client a sense of distance from the problem. Once the client's SUD level for the distantly held event drops, they may be able to approach the memory directly. Generally, if a practitioner keeps a client tapping even while experiencing overwhelming emotion, the degree of distress diminishes. Several clinicians have emphasized EFTs safety when treating mental health conditions (Flint, Lammers, & Mitnick, 2005; Mollon, 2007).

Conclusions

The evidence base for Clinical EFT as a single-session therapy for certain conditions like phobias is robust. EFT practitioners test client progress often during a session using SUD scores and noting cognitive shifts. Spontaneous cognitive reframes by clients are common. Good EFT practice targets specific childhood events rather than generalities, and EFT works best on conditions rooted in episodic memories. Clinical EFT practitioners are also trained in specialized techniques designed to address treatment challenges such as overwhelming emotional intensity and dissociation. Clients typically report significant reductions of their symptoms of anxiety, depression, and PTSD in a single session, though longer courses of treatment are indicated for these diagnoses. Certain treatment-resistant conditions like complex co-morbid PTSD can require prolonged treatment, therapeutic expertise, and support from other therapy techniques. Research indicates that EFT remediates a complex of co-occurring conditions, with PTSD, depression, and anxiety symptoms dropping simultaneously. In tandem with improvements in mental health, physical symptoms such as pain and autoimmune conditions can improve as the hormonal and brain wave correlates of stress are reduced.

Single sessions of EFT can encourage clients to persist with prescribed treatment by providing them with an experience showing that even psychological problems of long duration can be relieved. This may enhance their compliance with a full treatment program involving many other modalities. For these reasons, EFT is recommended as an efficient and effective front line primary care and mental health intervention.

Conflicts of Interest: The author derives income from trainings and books on the approach described.

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