Emotional Freedom Techniques to Treat Posttraumatic Stress Disorder in Veterans: Review of the Evidence, Survey of Practitioners, and Proposed Clinical Guidelines

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ABSTRACT

Background: High prevalence rates of posttraumatic stress disorder (PTSD) in active military and veterans present a treatment challenge. Many PTSD studies have demonstrated the efficacy and safety of Emotional Freedom Techniques (EFT).

Objectives: To develop clinical best practice guidelines for the use of EFT to treat PTSD, on the basis of the published literature, practitioner experience, and typical case histories.

Methods: We surveyed 448 EFT practitioners to gather information on their experiences with PTSD treatment. This included their demographic profiles, prior training, professional settings, use of assessments, and PTSD treatment practices. We used their responses, with the research evidence base, to formulate clinical guidelines applying the "stepped care" treatment model used by the United Kingdom's National Institute for Health and Clinical Excellence.

Results: Most practitioners (63%) reported that even complex PTSD can be remediated in 10 or fewer EFT sessions. Some 65% of practitioners found that more than 60% of PTSD clients are fully rehabilitated, and 89% stated that less than 10% of clients make little or no progress. Practitioners combined EFT with a wide variety of other approaches, especially cognitive therapy. Practitioner responses, evidence from the literature, and the results of a meta-analysis were aggregated into a proposed clinical guideline.

Conclusion: We recommend a Stepped Care model, with 5 EFT therapy sessions for subclinical PTSD and 10 sessions for clinical PTSD, in addition to group therapy, online self-help resources, and social support. Clients who fail to respond should be referred for appropriate further care.

INTRODUCTION

A number of systematic reviews consider the evidence for Emotional Freedom Techniques (EFT) as an "evidence-based" practice.[1-3] Studies are typically evaluated using criteria published by the American Psychological Association's (APA's) Division 12 Task Force on Empirically Validated Treatments, hereafter abridged as "APA standards."[4-6] The APA standards amalgamate current scientific consensus to identify 7 "essential" criteria that must be present for a study to qualify: randomization, sample size sufficient to establish statistical significance, a clear definition of the treatment population, valid and reliable assessments, blind interview assignments, a treatment manual, and sufficient data to allow the study's statistical methods to be assessed for appropriateness.[1-3] A minimum of 2 randomized controlled trials (RCTs) are required for a therapeutic method to be deemed "efficacious."

When proposing its own standards, the US Food and Drug Administration contemporaneously set a similar standard of 2 RCTs for drug trials.[7] A systematic review searching the scientific literature until April 2012 found 51 studies of EFT and allied methods collectively referred to as energy psychology. It found that "Criteria for evidence-based treatments proposed by Division 12 of the American Psychological Association were also applied and found to be met for a number of conditions, including PTSD."[1]

A systematic review and meta-analysis of 7 studies of EFT for posttraumatic stress disorder (PTSD) was recently reported.[8] It used the Cohen difference, an appropriate effect size for the comparison between 2 means, in which 0.2 indicates a treatment effect, 0.5 indicates a moderate treatment effect, and 0.8 indicates a large treatment effect. The meta-analysis found a large treatment effect, with a *d* of 2.96 when EFT was compared with normal care. Compared with eye movement desensitization and reprocessing (EMDR) and cognitive behavior therapy (CBT), no significant treatment difference was found, indicating similarities in efficacy between the 3 treatments. Two other systematic reviews with meta-analyses, 1 for anxiety (14 RCTs) and 1 for depression (20 RCTs and within-subjects studies), found "large" treatment effect sizes of 1.23 and 1.31, respectively.[9,10] Authors of all 3 meta-analyses used the APA standards as their quality-control criteria when selecting studies for inclusion. An online database of EFT research lists more than 100 clinical trials (www.Research.EFTuniverse.com).

A psychophysiologic intervention, EFT draws from 2 established therapies: CBT and exposure therapy. It adds the novel component of somatic stimulation using acupuncture points ("acupoints"). Developed in the early 1990s, EFT is described

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in subsequent editions of a standardized manual.[11,12] Clients are asked to assess the intensity of traumatic events before and after EFT using the Wolpe Subjective Units of Distress (SUD) measure,[13] an 11-point Likert scale ranging from 0 (no distress) to 10 (maximum distress). During a typical treatment session, clients recall a traumatic event and pair it with a statement of self-acceptance, such as "Even though I experienced [name of the event] I deeply and completely accept myself." They stimulate 7 acupuncture points with their fingertips (acupressure) by tapping on them or rubbing them while repeating the name of the event. If their SUD score is still high, they might describe the event in detail. An optional supplemental technique is called the 9 Gamut procedure and uses eye movements similar to those employed in EMDR. Often EFT is taught by therapists, physicians, nurses, and life coaches to patients as a method of self-care to use between treatment sessions. The method and typical applications are fully described elsewhere in the literature.[2,3]

To differentiate the acupressure component from the cognitive and exposure elements that EFT shares with other therapies, a meta-analysis examined six dismantling studies.[14] While retaining the cognitive and exposure parts of EFT, these six studies used control groups that either substituted an active treatment such as diaphragmatic breathing for acupressure or used pressure on sham acupoints. The meta-analysis found a large treatment difference between the groups that used authentic acupoints vs controls, indicating that acupressure is an active treatment ingredient in EFT's protocol and not merely an inert component.

Many studies conducted by independent research teams using a variety of different population samples, including veterans, adolescents, refugees, and disaster survivors, demonstrate the efficacy of acupressure stimulation as a treatment of PTSD.[15-23] In a typical RCT of veterans who met clinical criteria for PTSD (N = 59) and were assessed against a control group receiving treatment as usual (TAU), 86% of participants no longer met the criteria for PTSD after 6 sessions of EFT ($p < 0.0001$).[15] The military version of the Posttraumatic Stress Disorder Checklist (PCL-M),[24] a valid and reliable 17-item tool on which a score of 50 indicates the likelihood of a PTSD diagnosis, was used to assess symptoms. Mean PCL-M scores were 61.4 before treatment and 34.6 on posttreatment test. A replication of this study by an independent research team demonstrated similar results.[18]

A hospital in the United Kingdom's National Health Service conducted a study of a PTSD-positive outpatient population (N = 46) comparing EFT with EMDR and a waiting list with usual care.[17] They found both EFT and EMDR to remediate PTSD in a mean of 4 sessions ($p < 0.001$). An RCT of abused male adolescents (N = 16) used the Impact of Events Scale[25] to evaluate participant distress. Scores declined from 36 to 3 ($p < 0.001$) after a single EFT session.[16] Another RCT (N = 21) examined the impact of EFT on resiliency in veterans at risk of PTSD.[26] Six sessions produced a reduction in symptoms comparable to the results noted in a clinical population ($p < 0.0001$). Gains were maintained on follow-up in all 4 studies, whereas the wait-list participants did not improve.[16-18,26]

A systematic review of the literature includes 12 studies in which EFT demonstrated efficacy for a range of psychological conditions, such as PTSD, depression, and anxiety when delivered in the form of group therapy.[2] A written protocol called Borrowing Benefits, describing how to use EFT in groups, has been tested in both RCTs and outcomes studies.[12] In an uncontrolled study with veterans and their spouses, 218 participants were evaluated for PTSD symptoms before and after a 7-day retreat in which they used Borrowing Benefits and other EFT techniques.[27] Of the veterans, 83% exhibited clinical symptom levels on pretest, as did 29% of their spouses. On follow-up, only 28% of veterans and 4% of spouses still met the clinical cutoff ($p < 0.001$).[27] The Borrowing Benefits technique is described in detail in the EFT manual.[12] In a group, the practitioner works with one individual while witnesses self-apply EFT to their own personal issues. Studies of Borrowing Benefits find it efficacious for a wide variety of psychological conditions.[2]

Clinicians widely practice EFT and similar techniques. A recent survey critical of the method solicited responses from licensed psychotherapists using Listservs such as Acceptance and Commitment Therapy, the Society for a Science of Clinical Psychology, and the Association for Behavioral and Cognitive Therapies.[28] It found that 42% of therapists were using these modalities.

The Veterans Stress Project[29] is a charitable program of the National Institute for Integrative Healthcare that has served as a recruitment vehicle for several studies. Its Web site (www.StressProject.org) serves as a clearinghouse, allowing veterans to locate practitioners. The Veterans Stress Project also hosts an interactive virtual EFT coaching software program called Battle Tap and archives numerous testimonials from veterans who have used Battle Tap, individual therapy, and group EFT therapy to support their recovery from PTSD. These and other private and public initiatives pair veterans seeking treatment with practitioners offering EFT and similar therapeutic methods.

The objective of the current research was to develop clinical best practice guidelines for the use of EFT to treat PTSD. Toward that end, we evaluated practitioner experience and the published literature to arrive at a consensus statement.

METHODS

We undertook a survey of practitioners using EFT to treat PTSD (www.surveymonkey.com/s/GTZXD2B; SurveyMonkey, Palo Alto, CA:). The goals of the survey were to develop a demographic profile of practitioners, to evaluate how EFT is used in professional settings, and to determine current practices for PTSD treatment. Drawing on the results, the evidence base, and case histories, we formulated clinical guidelines for the use of EFT in the treatment of veterans and military personnel, with the "stepped care" model used by the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom as our framework.

The invitation to complete the survey was extended in February 2014 by several US and United Kingdom organizations: the National Institute for Integrative Healthcare, the Association for Comprehensive Energy Psychology, and the Association for Meridian and Energy Therapies, as well as informal networks of practitioners. We received responses from 448 practitioners. The number of those responding to each question is indicated

in Tables 1 to 5. Some survey questions allowed practitioners to select more than 1 option. For example, a practitioner could select both "nurse" and "retired" or for professional settings both "private practice" and "medical center"; thus; the number of responses to these questions exceeded 448.

One item asked practitioners to estimate how many sessions were required to treat complex PTSD (C-PTSD). Although C-PTSD does not appear as a diagnosis separate from PTSD in current diagnostic manuals, C-PTSD has been the subject of a great deal of debate in the clinical community. It is scheduled to appear in the upcoming edition of the World Health Organization's (WHO) *International Statistical Classification of Diseases and Related Health Problems.*[30] Usually, C-PTSD is defined as repetitive and prolonged trauma, such as that which can occur in a war zone, in cases of child abuse, or in domestic violence situations. It is regarded as more difficult to treat than single-incident PTSD.

Table 1. Demographic characteristics of practitioners surveyed

Characteristic	Number (%)[a]
Age (n = 436)	
Mean years (range)	58 (22-85)
Sex (n = 439)	
Men	121 (27.6)
Women	318 (72.4)
Profession (n = 446)[b]	
LMHP	168 (37.7)
Medical professional	29 (6.5)
AMP	141 (31.6)
Life coach	86 (19.3)
Retired	18 (4.0)
Other	73 (16.4)
Setting (n = 444)[b]	
Private practice	375 (84.5)
Medical center	30 (6.8)
University	4 (0.9)
Medical school	1 (0.2)
Mental health	43 (9.7)
Social services	11 (2.5)
Corporation	11 (2.5)
Other	53 (11.9)
Education (n = 446)	
High school	11 (2.5)
Some college	67 (15.0)
Bachelor's degree	88 (19.7)
Master's degree	174 (39.0)
Doctorate	85 (19.1)
Postdoctorate	21 (4.7)
Years in practice (n = 433)	
1-5	62 (14.3)
6-10	80 (18.5)
11-20	116 (26.8)
21-30	79 (18.2)
31-40	69 (15.9)
≥ 41	27 (6.2)

[a] Data are number (%) except for Age.
[b] Practitioners were permitted to check more than 1 option in this category; thus, the total exceeds the number of respondents for this category.
AMP = Alternative medicine practitioner; LMHP = Licensed mental health professional.

RESULTS

Table 1 summarizes the demographic characteristics of the 448 respondents. Most respondents were either licensed mental health professionals (37.7%) or alternative medicine practitioners (31.6%). More than 62% held a master's degree or higher, and 84.5% reported practicing in a private practice setting. The percentage of practitioners with 10 or fewer years of experience was 32.8%, 11 to 20 years was 26.8%, 21 to 30 years was 18.2%, 31 to 40 years was 15.9%, and 41 or more years in practice was 6.2%. Respondents had a mean age of 58 years, with a range of 22 to 85 years, and 72.4% were women.

Table 2 profiles the course of treatment for PTSD-positive clients. The PTSD clients constituted more than 20% of the practice for 37.0% of practitioners and less than 10% for 39.9% of respondents. Nearly half the respondents (45.2%) reported having worked with more than 50 clients with PTSD, and 41.4% said they spend more than 5 hours per week treating PTSD. Estimates of the average number of sessions needed to successfully treat complex PTSD were in the 1 to 5 range for 25.7% of

Table 2. Clients with posttraumatic stress disorder (PTSD), and experience and expectations regarding treatment course

Factor	Number (%)
Percentage of clients with PTSD (n = 429)	
1-10	171 (39.9)
11-20	99 (23.1)
21-50	95 (22.1)
≥ 51	64 (14.9)
Number of clients with PTSD (n = 436)	
0-10	96 (22.0)
11-20	55 (12.6)
21-50	88 (20.2)
51-100	71 (16.3)
101-200	44 (10.1)
201-300	21 (4.8)
≥ 301	60 (13.8)
Hours per week treating PTSD (n = 430)	
1-5	252 (58.6)
6-10	106 (24.7)
11-20	47 (10.9)
≥ 21	25 (5.8)
Number of sessions needed, complex PTSD (n = 420)	
1-5	108 (25.7)
6-10	157 (37.3)
11-15	63 (15.0)
16-20	39 (9.3)
21-25	22 (5.2)
26-30	9 (2.1)
≥ 31	22 (5.2)

the practitioners and 6 to 10 sessions for an additional 37.3% of practitioners. These estimates of sessions required align with those in the published literature.[15-23]

Table 3 summarizes responses regarding the perceived prevalence of PTSD, the use of diagnostic scales, and referrals. According to the US National Institutes of Health, the prevalence of PTSD in the general adult population is 3.5%,[31] but 91.7% of our survey respondents believed that this estimate is too low; only 7.6% assessed it as accurate. When asked to estimate the true prevalence, answers varied widely, but the most common answers were 6% to 10% (24.1%), 11% to 15% (19.7%), and 16% to 20% (18.2%).

Table 3. Measuring posttraumatic stress disorder (PTSD) and referrals

Factor	Number (%)
Accuracy of 3.5% NIH estimate of PTSD prevalence (n = 432)	
Too high	3 (0.7)
Accurate	33 (7.6)
Too low	396 (91.7)
Estimate of true PTSD prevalence, % (n = 395)	
5	17 (4.3)
6-10	95 (24.1)
11-15	78 (19.7)
16-20	72 (18.2)
21-25	38 (9.6)
26-30	31 (7.8)
≥ 31	64 (16.2)
Use of assessments to record client progress (n = 430)	
Yes	126 (29.3)
No	304 (70.7)
Ten most commonly used assessments (n = 153)[a]	
PTSD Checklist	87 (56.9)
Life Events Checklist	56 (36.6)
PTSD Symptom Scale	47 (30.7)
Trauma Symptom Inventory	37 (24.2)
Impact of Event Scale	37 (24.2)
Detailed Assessment of Posttraumatic Stress	36 (23.5)
Clinician-Administered PTSD Scale	30 (19.6)
Acute Stress Disorder Interview	25 (16.3)
Impact of Event Scale-Revised	23 (15.0)
Posttraumatic Stress Diagnostic Scale	22 (14.4)
Percentage of clients who continued treatment in conjunction with another professional (n = 429)	
0-10	267 (62.1)
11-20	78 (18.1)
21-50	41 (9.5)
≥ 51	43 (10.0)
Stopped treatment and referred out, % (n = 424)	
0-10	390 (91.8)
11-20	20 (4.7)
21-50	7 (1.6)
≥ 51	7 (1.6)

[a] Practitioners were permitted to check more than 1 option in this category; thus, the total exceeds the number of respondents for this category.
NIH = National Institutes of Health.

Validated instruments to track client progress were used by 29.3% of respondents, which is consistent with other surveys of mental health professionals.[32] Of the 448 respondents, 153 reported which assessments they use. The PTSD Checklist (PCL) was the most common, used by 56.9%, followed by the Life Events Checklist (36.6%) and the PTSD Symptom Scale (30.7%).

Practitioners rarely terminated work with a client and referred that client to another practitioner. For 91.8% of respondents, this occurred with 10% or fewer of clients. Continuing treatment in conjunction with another professional was more common.

Table 4 summarizes the most used therapy techniques, both EFT and non-EFT. Regarding use of EFT, 43.6% indicated they use it 51% or more of the time during their therapy sessions, and 27.4% said they use EFT 21% to 50% of the time. The 3 most common non-EFT methods used are cognitive therapy (45.7% of practitioners surveyed), life coaching (39.8%), and EMDR (31%). In an open-ended question, the non-EFT techniques that respondents listed as most beneficial for treating PTSD were cognitive therapy (12.0%), EMDR (10.2%), and meditation (7.7%).

Table 5 summarizes respondents' evaluations of PTSD therapy outcomes. Full rehabilitation in more than 60% of their clients was reported by 64.7% of respondents, with full rehabilitation in 90% of their clients being reported by 22.1% of respondents. Clinical trials of EFT in treating PTSD[15-23] show higher success rates than those most frequently reported by the respondents. Most respondents (89.8%) reported that less than 10% of their clients make little or no progress with EFT. This is reflected in the low dropout rates typical of EFT treatment programs; in the 7 studies reported in the meta-analysis of EFT for PTSD, the mean dropout rate was under 10%.[8]

We now present two typical case studies of veterans who presented for treatment at Veterans Affairs facilities and exhibited positive outcomes.

Case Study 1: Vietnam Combat Memories

More than four decades after returning from service in Vietnam, a male veteran presented for treatment. His issues included complex medical problems, multiple addictions, broken relationships, intolerable mental and emotional symptoms, nightmares, and homelessness. As one component of a multidisciplinary evidence-based treatment regimen at the Veterans Affairs Medical Center, he chose to learn and practice EFT as an adjunct to individual psychotherapy and group therapy.

During one appointment, he chose to use EFT on three persistent Vietnam combat memories that induced hyperarousal, reexperiencing, and avoidance. In the first, he was faced with an approaching enemy unit. In the second, his unit was attacked and most of his "battle buddies" were killed. In the third, he witnessed another adolescent warrior's life-threatening wounds and emotional suffering.

He provided an SUD score of 10 of 10 for the first 2 memories at the start of an hourlong appointment. After EFT, this fell to 0. He commented, "It's over. I'm home now. I'm safe." By the time he felt ready to apply EFT to the third memory, he reported distress

Table 4. Emotional Freedom Techniques (EFT) and non-EFT techniques

Factor	Number (%)
Percentage of time spent using EFT vs other methods (n = 426)	
0-10	63 (14.8)
11-20	64 (15.0)
21-50	117 (27.4)
≥ 51	182 (42.6)
7 most common other methods used (n = 352)[a]	
Cognitive therapy	161 (45.7)
Life coaching	140 (39.8)
EMDR	109 (31.0)
Health coaching	84 (23.9)
Tapas Acupressure Technique (TAT)	84 (23.9)
Psychodynamic approaches	83 (23.6)
Thought Field Therapy (TFT)	78 (22.2)
7 non-EFT techniques considered most beneficial (n = 325)[b]	
Cognitive therapy	39 (12.0)
EMDR	33 (10.2)
Meditation	25 (7.7)
Mindfulness	19 (5.9)
Hypnosis	16 (4.9)
NLP	11 (3.4)
Active listening	9 (2.8)
10 most-trained-in EFT techniques (n = 416)[a]	
Full Basic Recipe	385 (92.5)
9 Gamut Procedure	363 (87.3)
Shortcut Basic Recipe	351 (84.4)
Tell the Story Technique	333 (80.0)
Movie Technique	330 (79.3)
Floor to Ceiling Eye Roll	327 (78.6)
Aspects (emotional, physical, visual, cognitive)	325 (78.1)
Reframing	321 (77.2)
Borrowing Benefits	301 (72.4)
Chasing the Pain	296 (71.2)
10 EFT techniques considered most beneficial (n = 400)[a]	
Full Basic Recipe	253 (63.3)
Movie Technique	251 (62.8)
Tell the Story Technique	238 (59.5)
Aspects (emotional, physical, visual, cognitive)	238 (59.5)
Reframing	215 (53.8)
Tearless Trauma Technique	192 (48.0)
9 Gamut Procedure	188 (47.0)
Shortcut Basic Recipe	183 (45.8)
Customized Setup Phrasing and Flowing Setup Statements	154 (38.5)
Sneaking Up on the Problem	143 (35.8)

[a] Practitioners were permitted to check more than 1 option in this category; thus, the total exceeds the number of respondents for this category.
[b] The 7 non-EFT techniques question elicited a wide diversity of responses. Only the top 7 interventions are shown.
EMDR = Eye movement desensitization and reprocessing; NLP = neurolinguistic programming.

already reduced to 3 and, after EFT, 0. He appeared animated and chose to retell the stories, sharing graphic details without any evidence or report of emotional distress. He demonstrated positive cognitive shifts, reframing his perception to reflect that his quick actions under fire did not reflect cowardice, as he had believed since the incident, but rather that he had quickly done exactly what he was trained to do; this saved his own life and the lives of others. He smiled and laughed and reported immense relief, energy, and joy. By the following appointment, he reported that he had not had a single nightmare about Vietnam that week, for the first time in more than 40 years.

He continues to experience sustained symptom relief. He now has spent three years in recovery from substance abuse, the longest period yet. Veterans Affairs clinicians are gradually weaning him off his psychotropic medications. He uses EFT independently between appointments for sustained smoking cessation, ongoing healthy weight loss, and stress management. He has found stable housing and renewed healthy relationships with his family. He wants clinicians and other veterans to know this: "I was in a fight for my life. Don't give up. Keep trying. EFT helped me to cope with life. It relaxes me and puts me in a place where I want to be: from the inside looking out, not the outside looking in. It's given me a positive perspective on life. I have my family back, my mind got clearer, and I have more confidence. It's lovely."

Case Study 2: Military Sexual Trauma

When he came for treatment, this veteran was experiencing intolerable emotional, mental, and physical symptoms. He had been numbing these by self-medicating with multiple illicit substances for more than 30 years. He was homeless, with broken relationships and medical problems. Although skeptical about EFT "because it gave me the impression of being silly," he decided to try it. He states, "After a few sessions, with practice, I began to notice how I was able to release the distress and fears caused by old and new painful emotions . … One of its advantages [is] that I can and would utilize it at home, in school, or on the job as a form of relaxation."

Initially, he was reluctant to address his experience with military sexual trauma using any psychotherapeutic modality. He had already dropped out of other evidence-based modalities before trying EFT, stating that sessions were like "experiencing it all over again." During one appointment, he chose to use

Table 5. Posttraumatic stress disorder outcomes

Outcome	Number (%)
Percentage of clients fully rehabilitated (n = 410)	
0-30	57 (13.9)
31-60	87 (21.2)
61-90	175 (42.6)
≥ 91	91 (22.1)
Percentage of clients who made little or no progress (n = 412)	
0-10	371 (89.8)
11-20	24 (5.8)
21-50	13 (3.1)
≥ 51	4 (1.0)

EFT on his military sexual trauma experience, stating that it was blocking him from moving forward in his life. During the next four EFT appointments, he achieved resolution of his distressful symptoms. The positive effect persisted for the following year as he was weaned from his psychotropic medications.

During an EFT session, a defining moment occurred when he was stuck at a persistent level of emotional distress, a 5 to 6 on the SUD scale. He used EFT on a particular aspect of his sexual trauma experience, "the look on their faces." (For a discussion of "Aspects," see *The EFT Manual,* p 100[12]). Once his SUD score fell to 0, he stated: "It doesn't matter now. I don't have to live my life this way anymore. It's over. I know it happened, but I can think about it now without feeling those symptoms or wanting to go out and use [illegal substances]. I'm at peace now. I feel as if the weight of the world has been lifted off my shoulders." The clinician observed positive cognitive shifts, relaxed facial and body posture, and smiles in support of his comments.

This veteran has now achieved more than five years in recovery from substance abuse, his longest time ever. His PTSD symptoms are resolved. He is enjoying healthy relationships with family and friends. He is independent, living in his own apartment, attending classes with the goal of employment, and experiencing a positive quality of life. He continues to use acupuncture, meditation, and EFT. He wants clinicians and other veterans to know this: "These techniques have given me a new outlook on life and to see new possibilities in the hope of setting goals and to visualize stability in my life, free of tension. Most of all it has helped me to accept my faults, forgive myself and others, to make amends, and change my negative feelings and behaviors into positive ones, giving me a sense of peace, lots of joy, and much love and compassion for others."

Additional veteran case studies; letters from veterans, practitioners, and members of the US Congress; and transcripts from congressional testimony on EFT may be viewed at the Web site of the Veterans Stress Project (www.StressProject.org).[29]

DISCUSSION

On the basis of the studies outlined earlier, the results of the survey, and expert consensus, we propose the following treatment guidelines for using EFT for PTSD.

Proposed Treatment Guidelines

The NICE guidelines use a "stepped care" model that we believe is an appropriate framework for treating PTSD.[33] We also believe that the risk of PTSD should be mitigated using a proactive approach to develop resiliency. In the NICE model, the patient is offered the least intrusive potentially effective intervention first. If the patient does not benefit, or prefers not to continue, s/he is offered the next step. The NICE guidelines emphasize the importance of integrated care, because many mental health conditions share similar neural pathways. This position is reinforced by results of EFT studies, which show the symptoms of depression, anxiety, and other psychological conditions declining simultaneously after PTSD treatment.[2,34] A study of 216 health care workers tracked whether participants used EFT after the intervention period and found that those who used EFT afterward experienced greater symptom reductions than those who did not.[35] At the Warrior Combat Stress Reset Program at Fort Hood, TX, EFT has been used for many years, along with EMDR and other complementary therapies.[36] Fort Hood clinicians typically use EMDR during sessions while teaching EFT to patients as a method of managing stress between sessions. Practitioners typically recommend that clients use EFT between sessions as well as during them, and after courses of treatment have ended to manage the stress of daily life.[2,12] The following recommendations are based on NICE Guideline 26, titled "The Treatment of PTSD in Adults and Children in Primary and Secondary Care."[37]

The NICE Step 1 guideline advocates identification, assessment, psychoeducation, active monitoring, and referral for further assessment and interventions. In Step 1, the PCL or PCL-M is used to assess PTSD symptom levels, and further treatment is based on the cutoff scores. Although several cutoff points for the PCL-M have been evaluated, a score of 35 or greater indicates PTSD risk probability in a military population and is appropriate for Step 1.[38] Veterans Affairs guidelines describe a 10- to 20-point reduction in PCL scores as representing clinically significant change.[39] Although reduction of symptoms below a score of 50 results in a client falling below the cutoff for a PTSD diagnosis, we recommend a treatment goal of below 35 because this reduces the risk of delayed-onset PTSD. If indications of complex PTSD are apparent, a multimodal approach encompassing more than 10 sessions might be considered. These scores should be updated as subsequent versions of the PCL are implemented and validated. For other assessments, accepted cutoff scores for clinical and at-risk symptom levels can be substituted for those of the PCL.

NICE Step 2 guidelines for PTSD recommend treatment using Trauma-Focused Cognitive Behavior Therapy (TFCBT) or EMDR. These recommendations did not include EFT because most of the earlier referenced studies had not been published at the time the guidelines were developed. To make EFT available to a PTSD-positive population, we recommend an update of the guidelines based on currently published research. We propose that EFT be added to the recommended treatments based on the following criteria:

Subclinical Scores (35-49) in Initial Assessment

Treatment as usual plus A) 5 individual EFT therapy sessions and B) 1 instructional session on using the Battle Tap interactive online coach plus C) 3 Borrowing Benefits group therapy sessions. If members of the client's family are willing and able to attend Borrowing Benefits sessions, they should be invited.

Assessment 2: After the primary treatment program is complete, if symptom levels are persistently more than 34, A) 3 more sessions plus B) 1 additional Battle Tap instructional session.

Follow-up Assessment: 3 months after the final therapy session, if symptom levels are persistently above 34, monitor the client and perform regular follow-up assessments.

Clinical Scores (> 49) in Initial Assessment

Treatment as usual plus A) 10 individual EFT therapy sessions plus B) 2 sessions on using Battle Tap plus C) 5 Borrowing

Benefits group sessions. If members of the client's family are willing and able to attend Borrowing Benefits sessions, they should be invited.

Assessment 2: After the primary treatment program is complete, if symptom levels are persistently above 40, A) 3 more individual therapy sessions plus B) 1 additional Battle Tap session plus C) 5 additional Borrowing Benefits group sessions.

Follow-up Assessment: 3 months after final therapy session, if clinical symptoms persist, escalate intervention to Steps 3 and 4 of the NICE guidelines, which advocate appropriate medication and intensive individual psychotherapy.

RISK MITIGATION FOR ACTIVE-DUTY WARRIORS

Instead of waiting until PTSD is diagnosed, we recommend a proactive approach using psychoeducation and Borrowing Benefits to mitigate the risk of development of symptoms in active-duty warriors. This has two components: the first applicable to the predeployment phase and the second in the postdeployment phase.

Predeployment Component: Independent of PCL-M assessment, three days of group EFT training using Borrowing Benefits as stress inoculation therapy, including an introduction to Battle Tap.

Postdeployment Component: Independent of PCL-M assessment, seven days of group EFT therapy using Borrowing Benefits and Battle Tap. Individual psychotherapy sessions as requested by participants.

CONCLUSION

According to published reports, systematic reviews of the published evidence, a meta-analysis of seven RCTs, and practitioner consensus, most cases of PTSD are remediated in ten EFT sessions or less. As a safe, efficacious, and easily learned self-help method, EFT should be offered to clients as an initial treatment option immediately after diagnosis. Group therapy involving family members may reinforce treatment effects through social support, and access to Battle Tap provides veterans and warriors with access to EFT at times and places of their own choosing. A structured evidence-based practice protocol should be widely disseminated to clinicians and institutions bearing the burden of PTSD treatment. For those patients who do not respond, appropriate medication and intensive individual psychotherapy is recommended, especially in cases of complex PTSD. ❖

Disclosure Statement

Dr Church is a stockholder in Energy Psychology Group, an organization providing training services and publications to medical and mental health professionals; he also receives income from presentations and publications related to the therapeutic method discussed. Dr Feinstein is the CEO of Innersource and Volunteer Executive Director of Energy Medical Institute.

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References

1. Feinstein D. Acupoint stimulation in treating psychological disorders: Evidence of efficacy. Rev Gen Psychol 2012 Dec;16(4):364-80. DOI: https://doi.org/10.1037/a0028602.
2. Church D. Clinical EFT as an evidence-based practice for the treatment of psychological and physiological conditions. Psychology 2013;4(8):646-54. DOI: https://doi.org/10.4236/psych.2013.48092.
3. Church D, Feinstein, D, Palmer-Hoffman J, Stein PK, Tranguch A. Empirically supported psychological treatments: The challenge of evaluating clinical innovations. J Nerv Ment Dis 2017 Oct;202(10):699-709. DOI: https://doi.org/10.1097/nmd.0000000000000188.
4. Chambless DL, Sanderson WC, Shoham V, et al. An update on empirically validated therapies. Clin Psychol 1996;49:5-18.
5. Chambless DL, Hollon SD. Defining empirically supported therapies. J Consult Clin Psychol 1998;66(1):7-18. DOI: https://doi.org/10.1037//0022-006x.66.1.7.
6. Chambless DL, Baker MJ, Baucom DH, et al. Update on empirically validated therapies, II. Clin Psychol 1998 Winter;51(1):3-16.
7. US Department of Health and Human Services; Food and Drug Administration; Center for Drug Evaluation and Research (CDER); Center for Biologics Evaluation and Research (CBER). Guidance for industry: Providing clinical evidence of effectiveness for human drug and biological products [Internet]. Rockville, MD: US Department of Health and Human Services; 1998 May [cited 2017 Mar 1]. Available from: www.gmp-compliance.org/guidemgr/files/CLINEFF.PDF.
8. Sebastian B, Nelms J. The effectiveness of Emotional Freedom Techniques in the treatment of posttraumatic stress disorder: A meta-analysis. Explore (NY) 2017 Jan-Feb;13(1):16-25. DOI: https://doi.org/10.1016/j.explore.2016.10.001.
9. Clond M. Emotional Freedom Techniques for anxiety: A systematic review with meta-analysis. J Nerv Ment Dis 2016 May;204(5):388-95. DOI: https://doi.org/10.1097/NMD.0000000000000483.
10. Nelms JA, Castel L. A systematic review and meta-analysis of randomized and nonrandomized trials of Emotional Freedom Techniques (EFT) for the treatment of depression. Explore (NY) 2016 Nov-Dec;12(6):416-26. DOI: https://doi.org/10.1016/j.explore.2016.08.001.
11. Craig G. The EFT manual. 1st ed. Santa Rosa, CA: Energy Psychology Press; 2008.
12. Church D. The EFT manual. 3rd ed. Santa Rosa, CA: Energy Psychology Press; 2013.
13. Wolpe J. The practice of behavior therapy. 2nd ed. New York, NY: Pergamon Press; 1973.
14. Church D, Feinstein D, Gallo F, Yang A. Is acupressure an active or inert ingredient in Emotional Freedom Techniques (EFT)? A meta-analysis of dismantling studies. Presented at Omega Institute, Rhinebeck, NY, October 2016.
15. Church D, Hawk C, Brooks AJ, et al. Psychological trauma symptom improvement in veterans using emotional freedom techniques: A randomized controlled trial. J Nerv Ment Dis 2013 Feb;201(2):153-60. DOI: https://doi.org/10.1097/nmd.0b013e31827f6351.
16. Church D, Piña O, Reategui C, Brooks A. Single-session reduction of the intensity of traumatic memories in abused adolescents after EFT: A randomized controlled pilot study. Traumatology 2012 Sep;18(3):73-9. DOI: https://doi.org/10.1177/1534765611426788.
17. Karatzias T, Power K, Brown K, et al. A controlled comparison of the effectiveness and efficiency of two psychological therapies for posttraumatic stress disorder: Eye movement desensitization and reprocessing vs. emotional freedom techniques. J Nerv Ment Dis 2011 Jun;199(6):372-8. DOI: https://doi.org/10.1097/nmd.0b013e31821cd262.
18. Geronilla L, Minewiser L, Mollon P, McWilliams M, Clond M. EFT (Emotional Freedom Techniques) remediates PTSD and psychological symptoms in veterans: A randomized controlled replication trial. Energy Psychology: Theory, Research, and Treatment 2016
Nov 1;8(2):29-41. DOI: https://doi.org/10.9769/epj.2016.8.2.lg.
19. Gurret JM, Caufour C, Palmer-Hoffman J, Church D. Post-earthquake rehabilitation of clinical PTSD in Haitian seminarians. Energy Psychology: Theory, Research, and Treatment 2012 Nov;4(2):26-34. DOI: https://doi.org/10.9769/epj.2012.4.2.jph.
20. Connolly S, Sakai C. Brief trauma intervention with Rwandan genocide survivors using thought field therapy. Int J Emerg Ment Health 2011;13(3):161-72.
21. Sakai CE, Connolly SM, Oas P. Treatment of PTSD in Rwandan child genocide survivors using thought field therapy. Int J Emerg Ment Health 2010 Winter;12(1):41-9.

22. Stone B, Leyden L, Fellows B. Energy psychology treatment for orphan heads of households in Rwanda: An observational study. Energy Psychology: Theory, Research, and Treatment 2010 Nov;2(2):73-82. DOI: https://doi.org/10.9769/epj.2010.2.2.bs.
23. Stone B, Leyden L, Fellows B. Energy psychology treatment for posttraumatic stress in genocide survivors in a Rwandan orphanage: A pilot investigation. Energy Psychology: Theory, Research, and Treatment 2009 Nov;1(1):73-82. DOI: https://doi.org/10.9769.EPJ.2009.1.1.BS.
24. Weathers FW, Huska JA, Keane TM. PCL-M for DSM-IV. Boston, MA: National Center for PTSD—Behavioral Science Division; 1991.
25. Horowitz M, Wilner N, Alvarez W. Impact of Event Scale: A measure of subjective stress. Psychosom Med 1979 May;41(3):209-18. DOI: https://doi.org/10.1097/00006842-197905000-00004.
26. Church D, Sparks T, Clond M. EFT (Emotional Freedom Techniques) and resiliency in veterans at risk for PTSD: A randomized controlled trial. Explore (NY) 2016 Sep-Oct;12(5):355-65. DOI: https://doi.org/10.1016/j.explore.2016.06.012.
27. Church D, Brooks AJ. CAM and energy psychology techniques remediate PTSD symptoms in veterans and spouses. Explore (NY) 2014 Jan-Feb;10(1):24-33. DOI: https://doi.org/10.1016/j.explore.2013.10.006.
28. Gaudiano BA, Brown LA, Miller IW. Tapping their patients' problems away? Characteristics of psychotherapists using energy meridian techniques. Research on Social Work Practice 2012 Nov;22(6):647-55. DOI: https://doi.org/10.1177/1049731512448468.
29. Stressproject.org [Internet]. California: Veterans Stress Project; 2017 [cited 2017 Mar 6]. Available from: www.stressproject.org.
30. World Health Organization Executive Board, 139th session. International statistical classification of diseases and related health problems: Update on the eleventh revision. Report by the Secretariat [Internet]. Geneva, Switzerland: World Health Organization; 2016 Apr 15 [cited 2017 Mar 1]. Available from: http://apps.who.int/iris/bitstream/10665/250807/1/B139_7-en.pdf.
31. Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry 2005 Jun;62(6):617-27. DOI: https://doi.org/10.1001/archpsyc.62.6.617.
32. Miller SD, Hubble MA, Chow DL, Seidel JA. The outcome of psychotherapy: Yesterday, today, and tomorrow. Psychotherapy (Chic) 2013 Mar;50(1):88-97. DOI: https://doi.org/10.1037/a0031097.
33. National Institute for Health and Care Excellence. How NICE clinical guidelines are developed: An overview for stakeholders, the public and the NHS. 4th ed [Internet]. London, United Kingdom: National Institute for Health and Care Excellence; 2009 Jan [cited 2017 Mar 1]. Available from: www.nice.org.uk/guidance/cg177/documents/osteoarthritis-update-stakeholder-lists-and-how-to-register2.
34. Church D. Reductions in pain, depression, and anxiety symptoms after PTSD remediation in veterans. Explore (NY) 2014 May-Jun;10(3):162-9. DOI: https://doi.org/10.1016/j.explore.2014.02.005.
35. Church D, Brooks AJ. The effect of a brief EFT (Emotional Freedom Techniques) self-intervention on anxiety, depression, pain and cravings in healthcare workers. Integrative Medicine: A Clinician's Journal 2010 Oct-Nov;9(4):40-4.
36. Libretto S, Hilton L, Gordon S, Zhang W, Wesch J. Effects of integrative PTSD treatment in a military health setting. Energy Psychology: Theory, Research, and Treatment 2015 Nov;7(2):33-44. DOI: https://doi.org/10.9769/EPJ.2015.11.1.SL.
37. NICE. Post-traumatic stress disorder: Management [Internet]. London, UK: National Institute for Health and Care Excellence; 2005 Mar 23 [cited 2017 Mar 1]. Available from: www.nice.org.uk/guidance/cg26.
38. Bliese PD, Wright KM, Adler AB, Cabrera O, Castro CA, Hoge CW. Validating the primary care posttraumatic stress disorder screen and the posttraumatic stress disorder checklist with soldiers returning from combat. J Consult Clin Psychol 2008 Apr;76(2):272-81. DOI: https://doi.org/10.1037/0022-006x.76.2.272.
39. US Department of Veterans Affairs, National Center for PTSD. PTSD checklist for DSM-5 (PCL-5) [Internet]. Washington, DC: US Department of Veterans Affairs. Available from: www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp.