EFT for PTSD

(Posttraumatic Stress Disorder)

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Please consult qualified health practitioners regarding your use of EFT.

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A Quick Start Guide to Using EFT for PTSD

If you're reading this book, it's for one of three reasons.

1. You have been diagnosed with posttraumatic stress disorder (PTSD) or you suspect you might have PTSD.
2. A family member of yours has PTSD. Perhaps your husband, wife, daughter, or son is a veteran with PSTD. Perhaps a family member has PTSD as the result of a car crash, assault, or some other traumatic event. Perhaps you suspect the erratic behavior of your spouse is due to childhood abuse. You're motivated to find out more and to help a loved one.
3. You work with people who have PTSD.

No one picks up a book called *EFT for PTSD* for light recreational reading. I know you need answers, and I'm here to give them to you. This book gets right to the point.

It summarizes the work of the world's top experts in PTSD and EFT. I'm going to tell you, bluntly and frankly, what's possible and what's not. I'm going to lay out why PTSD is such an insidious disease, why it gets worse over time without proper treatment, how it devastates families, marriages, and communities, and what sort of changes you can realistically expect if you learn and practice EFT.

Giving You Hope

This book was also written to give you hope. A huge amount of time went in to writing it, into inviting top people in their fields to share their expertise, and into soliciting stories from members of the EFT community about their direct experiences with PTSD. All these people contributed because they want to give hope to those who suffer from PTSD.

You need hope when you're dealing with PTSD. As we'll discover together in the coming chapters, PTSD is a devastating condition. It's not just bad for the person diagnosed. It affects brothers, sisters, husbands, wives, sons, and daughters. Its effects spread out to the whole community (McFarlane & van der Kolk, 2007).

PTSD often becomes worse over time. The reason for this is that it changes the brain. The parts of the brain responsible for learning and happiness actually shrink, while cognitive function and memory degrade (Peters et al., 2010; Hedges & Woon, 2010; Felmingham et al., 2009). A veteran may show no symptoms for a year or two after returning from combat but then develop PTSD. Family members of Vietnam veterans often notice them

getting worse 30 or 40 years later. All those years of building up the neural circuitry of stress increases its efficiency, while those parts of the brain responsible for learning and memory wither away. It's not a pretty picture in the long term, and it's a problem that does not go away if you ignore it.

With Emotional Freedom Techniques (EFT), there is real and tangible hope. I helped start a nonprofit a few years back called the Veterans Stress Project, and we've now worked with more than 10,000 veterans and family members with PTSD. Many of them report full recoveries, and you can read their stories at StressProject.org.

We've also performed a series of scientific studies, and the results from these are consistent: close to 90% of veterans who use EFT recover from PTSD. Not only do their symptoms improve after treatment, but also the results hold over time. Once they're healed, they don't go back.

These studies, published in peer-reviewed professional journals and performed to rigorous experimental standards, demonstrate that the stories you'll read in this book aren't the exception, they're the rule. These aren't a few isolated successes in a sea of failures; that 90% success rate is typical. Yes, there are some sufferers who try EFT and don't get better, but they are a small minority.

My Story

First, I need to make a confession. I have struggled with PTSD most of my adult life. I have never told this story publicly; I'm telling it now for the first time.

I didn't know I had PTSD till I was in my late 40s. I always knew I'd blanked out my childhood from 0 to around 10 because it was too horrible to remember. I have three memories from the age of 5, one from the age of 7, and one from the age of 10. I have a few from the ages of 12 to 15, and none of them are good.

One 5-year-old memory is fairly detailed. I'm walking to kindergarten through the snow, carrying my lunchbox. I'm looking down at my shoes, and dragging them through the snow to create a trail, rather than picking them up to plant nice crisp footprints in the white powder. I'm dragging my feet because I'm terrified of what I'm about to encounter.

My father was working at the Castle, a missionary establishment in Colorado Springs. We'd just moved to the United States, and I was enrolled in Howbert Elementary School. I didn't fit in. I had the wrong accent and the wrong clothes. Our family had no money, so my clothes came from the "missionary barrel" at church. That's a place where other families discard their unwanted clothes.

But my mother did not allow me to select anything I wanted from the missionary barrel. I was only permitted to select one garment every few weeks, and I'd learned that selecting the best was frowned upon as "vanity," one of the Seven Deadly Sins. Once I had my heart set on a warm jacket, but when my mother saw it, she forced me to put it back. By the age of 5, I'd been trained to select the worst of the cast-off clothes. So I went to school dressed in the scrapings from the bottom of the missionary bar-

rel. Even my lunchbox was a discarded oddity meant for a younger child. I sat alone in the playground during breaks. I didn't know the culture, and didn't know how to make friends.

Among the other indignities Howbert heaped on me was a diagnosis that I needed remedial speech education, presumably to correct my British accent. The speech education classes certainly produced an effect. Shamed for the way I expressed myself, I developed a stutter, a fear of public speaking, a sense of worthlessness, an aversion to being seen or heard, and a lifelong speech impediment.

My mother was not a happy person. During a physical exam many years ago, the doctor asked me how I came to have scars from second- and third- degree burns on my face and body. Like most of the rest of my childhood, I could remember nothing. While there are blank spaces where my early memories should be, I do have a recollection of the emotional tone of living with my mother: sheer terror.

I realized I had PTSD when in my 40s I began to work with veterans. As I read their lists of symptoms, I saw myself in them. At that time I was also in an abusive relationship, and when it ended, I felt like I had awakened from a dream. I realized I'd been selecting relationship partners who were either emotionally dead, which felt safe, or emotionally expressive though abusive. I'd chosen either people who were the exact opposite of my mother, or exactly like my mother. I'd carried the trauma of my past into my present.

Virginia Satir was a legendary therapist of the 20th century and one of the founders of the field of marriage and family therapy. She defined a marriage as two sets of dysfunctional family patterns coming together to perpetuate themselves into the next generation.

I was a poster child for her bleak prognosis. Till my late 40s, I trembled at the thought of making a public speech. I was married for a long time to a partner whose default setting was criticism, and seemed incapable of kind or supportive words. This gradually eroded what little self-esteem I had. After a decade in that marriage, I believed I was worthless, with no value in the world, and with nothing important to say. As a child, I acquired the core belief that that my entire life was a mistake, and I should never have been born. I chose a wife who reinforced my self-estimation.

I also had many other characteristics of PTSD. I was completely out of touch with my body. I regarded it as little more than an unattractive platform for carrying my head around. I'd gone to school dances as a teenager, and besides feeling shut down with embarrassment, I could not move my limbs with any sort of grace or coordination. I also could not distinguish right from left, and I often transposed digits in numbers and letters in words.

When I began to spend time with people other than my ex-wife, I slowly began to realize that not everyone responded to me with criticism; in fact, many people valued what I brought to the conversation.

Within a few years, I had tapped away most of my fears with EFT. I had established a regular meditation

practice. I had written a best-selling book, *The Genie in Your Genes*. I was speaking at many medical and psychological conferences each year, and through radio and online shows I was speaking to up to 10 million people annually. Often I received standing ovations. I received many letters and e-mails from people telling me that my work had completely changed their lives. I changed my whole career path from focusing on early retirement to focusing on brining this work to as many people as possible. In addition to the Veterans Stress Project, I founded the National Institute for Integrative Healthcare, started Energy Psychology Press, and assembled the largest archive of EFT stories online at EFT Universe.

Today I'm remarried to a woman who loves me unconditionally. She sits in the front row when I deliver keynote speeches, her eyes shining with love. After every speech, she holds me close while telling me how wonderfully I spoke and how blessed people in the audience felt. If I feel I performed under par, she tells me that nobody noticed. Even after many years together, when we travel to new places, strangers often mistake us for newlyweds. We give thanks every day when we wake up to the miracle of love in which we live.

Since starting this journey of healing, my life has changed completely in every dimension. If I can heal, you can too!

In this book, I hope to inspire you with the stories of many people who, like me, have reclaimed their lives from the ravages of PTSD and set themselves up for a whole new future. There are many stories in the book, as well

as a summary of the research evidence showing that EFT can rehabilitate people with PTSD.

Here are two stories of other people who've used EFT to address their PTSD symptoms. In the first account, Winston Scott, a certified clinical hypnotherapist, writes about how he used EFT to help a firefighter who suffered from posttraumatic stress—not as a result of the stress in his profession but from a childhood trauma that occurred when he was 3 years old.

EFT Resolves 35 Years of PTSD

By Winston "Brad" Scott, CCHT

At an EFT seminar in Boston, I had a lunchtime encounter with a local firefighter. My friend and I went out to get some non-hotel food and saw a deli across the road. There was a fire truck parked beside it, so we thought it had to have good eats. After we entered and saw the long line, we knew this was probably true.

I ended up standing beside a fireman and, just making small talk, told him he was the reason we were here. He wondered about this and we told him. "If the fire department eats here, then it must be good food." He noted that we weren't "from around here" (he had a very strong Bostonian accent and I live in Canada) and asked what brought us down this way. Instead of trying to explain EFT at that point, I just said I was a hypnotherapist (most people understand that easily) and I was at a seminar to learn about a great new stress management tool.

He looked at me questioningly and then blurted out that I should be using him as my "monkey." I asked him what he meant and he said that he felt completely stressed out and was seriously feeling—and these are his words—"ready to jump."

Of course, I asked him what was up. He proceeded to tell me that he had buried seven brothers (firemen) in the last 7 weeks and he was just too young for this and constantly in a highly stressed state. He didn't think he could "take any more."

I noticed then that the muscles in his neck and jaw were all clenched. I thought, if he is that stressed waiting for a sandwich, then EFT is going to be his new best friend. I asked him if he would like to experiment and check out the technique. He said that he would be at the firehall for the next 8 hours barring a fire and would be more than willing to try anything, as he was desperate. He told me that if I was willing, we could check it out, but he doubted it would help.

I have a total respect for firefighters, as my grandfather was a captain in the Toronto fire department, so I decided to skip a little of the seminar and go over.

We met at the door of the station and he took me back to a private area with a couple of seats.

This next part is a testament to getting yourself out of the way. I went in there thinking that it was a current issue that was stressing him (the loss of his "brothers" in such a short period). This proves that to attack any problem with a preconceived notion is a mistake. We

started tapping around that issue, using the basic shortcut method, but didn't get a lot of movement.

Because we weren't really getting anywhere, I decided to ask a favorite EFT question: If there was one thing in your life you could eliminate or do over, what would it be? There was no hesitation. He had his issue immediately. It turned out that, at the age of 3, he believed that he had killed his best friend. Two of his friends and he had snuck in to a swimming pool. To use his words, "Three went in and only two came out." His belief was he killed his friend. He believed he must have pushed his friend in because that is the kind of thing he would have done. He didn't actually remember it. He just believed he did and he believed that he should be punished and held accountable for it. He didn't feel he had the right to a happy life.

This brave man had been living with posttraumatic stress for 35 of his 38 years. He told me he had never really "felt right inside," so we tapped on several aspects of this incident. Whenever he got "stuck," I used the 9 Gamut Procedure and immediately his SUD level dropped significantly. I know a lot of people have shelved the 9 Gamut, but when you get stuck, it is a remarkable tool.

I don't want to go into what we tapped on as it is a very personal story and the details might not respect his right to privacy. Suffice to say that, 40 minutes later, he thanked me, gave me a hug, and told me that he had been to every doctor in town and hadn't been able to resolve anything. He said he felt as if a great weight had been taken off his shoulders. He looked like a different person.

His jawline was relaxed. His neck muscles weren't knotted and sticking out.

I felt really honored to be able to show such a brave man the power of EFT and that there was a way to truly let go of all the destructive trauma and guilt.

I feel very privileged to call this man my friend. We have stayed in touch and, months later, he reports that he still feels very calm about the situation. He commented, "Hey, I've done my time. I really do deserve some peace."

I am so in awe of EFT and the peace it can bring about.

* * *

Notice that the fireman's immediate distress was linked to burying seven fellow firefighters in the previous *7* weeks, but that the practitioner wasn't getting anywhere using EFT on those deaths. They didn't make progress until the practitioner asked a key question of the kind you'll be trained to ask in this book. That led to the identification of an underlying event that was the true cause of the fireman's stress.

Also notice that his distress about the current deaths was resolved when he tapped on the childhood event. They never even needed to tap on the current events. The reason adult events disturb us is almost always because they recapitulate losses we suffered as children. Until we dig deep, and uncover those early causes, trying to feel better about the current situation is usually not successful. But when we resolve the early trauma, the later ones automatically diminish in emotional impact.

In the next account, certified EFT practitioner Angela Amias writes about a session during which the client made the connection between a current vision problem and a past unhealed rape trauma, and cleared both with EFT.

EFT Helps Heal Rape Trauma

By Angela Amias, LISW, EFT INT-1

At times, past trauma can manifest itself in the physical body in unexpected ways.

In this case, Josie, a client in her 30s, was working through persistent negative feelings about the break-up of a relationship that had occurred a few years prior to our work together. In addition, and seemingly unrelated to this issue, she had recently been experiencing unusual problems with her vision, for which physicians had been unable to find any physical explanation.

While discussing her feelings about the break-up during one session, Josie said that what really bothered her about the relationship was "I never felt like I had any control." After tapping briefly on the phrase, "Even though I had no control, I deeply love and accept myself," she stopped and reported that she was having trouble with her vision again.

Everything in her visual field seemed to be tilting to the left.

She said, "It's like I'm not seeing things correctly."

This was making it difficult for her to focus on our work.

At this point, neither of us made a connection between the issues we were discussing and this visual problem, but since the client was distressed by the visual disturbance, we decided to try EFT to see if it might have an effect.

We tapped on:

Even though I'm not seeing things correctly, I deeply love and accept myself.

As Josie continued tapping on the phrase *"I'm not seeing things correctly,"* she suddenly began to cry and told me she was experiencing visual flashbacks of a sexual assault that had occurred in her early 20s.

While she had mentioned this experience before, she had downplayed the event, describing it as an unpleasant sexual experience rather than rape, because it had occurred within the context of a long-term relationship. Now, however, her intensity was very high and we tapped for several minutes without speaking until she was calmer and said she was ready to work through this memory.

When I asked her to guess at the intensity of the experience without thinking directly about it, she rated it a 10. We tapped until it was at a 5 and then I asked her to pretend this experience was a movie and give it a title. I reminded her not to watch the movie in her mind but just focus on the title.

She gave it the title "Man rapes woman" and rated her intensity about the title at an 8. After tapping on this title for a few rounds, her intensity increased to a 10 and she said, "I really hate the word 'rape.'" So we switched from tapping on the title to tapping on the word "rape,"

"Even though I really hate that word…" to *"Even though I hate the word 'rape'…"* until her intensity around that word had dropped to a 1.

We then tapped on the title until it had also dropped to a 1.

At this point, we were ready to begin working through the actual traumatic event. In order to prevent Josie from being flooded by emotions or possibly reexperiencing the event, we created several barriers between her and the experience. She imagined the movie on a movie screen, pulled curtains across the screen, and imagined she was in a separate building far from the theatre where this movie was playing.

Only at this point, when safety had been established, did we slowly work through the experience, tapping on each part of the story that contained an emotional charge before moving to the next part. By the end of the session, she was able to tell the entire story of her experience without experiencing any emotional intensity.

Rape is a violation of the fundamental integrity of one's own body.

Looking back, it's easy to see the connection between this experience and Josie's difficulty getting over a relationship in which she felt this lack of control in other ways. Because she had actively suppressed her feelings about this experience for several years, it had been difficult for her to understand why she was having such a hard time with her recent break-up.

Her description of her visual problem, "I'm not seeing things clearly," was a perfect metaphor for her inability to see the connection between her current emotional experience and this past unhealed trauma.

Once that trauma was uncovered and healed, she no longer needed the physical symptom to get her attention. In fact, after working though all the aspects of this trauma, Josie experienced no further episodes of visual disturbance.

* * *

These aren't isolated stories. As you read this book, you'll see the accounts of many more people who healed in this way. Your hope will grow, and it will be well founded. If you're trying EFT for the first time, you'll be amazed by how quickly you can heal traumatic memories. With practice, you'll look back on your life, as I did, and find you've become a different person.

Tapping

EFT is often called "tapping" because one of its key components is tapping with your fingertips on acupuncture points on your body. Acupuncture has been proven effective for a variety of problems in many scientific studies (Braverman, 2004). Those problems include physical symptoms such as pain as well as psychological problems such as PTSD.

While acupressure points (shortened to "acupoints") can be stimulated by inserting needles at those points, they can also be stimulated without needles. One example

is the Japanese massage method called Shiatsu, which massages the points by hand. In this chapter, I'll show you how to stimulate a series of acupoints on your own body by tapping on them with your fingertips. Pressure on acupoints seems to have much the same effect as needling them (Cherkin et al., 2009).

Acupuncture theory teaches that energy flows through our body along pathways called meridians. These have been mapped using modern scientific instrumentation (Schlebusch, Maric-Oehler, & Popp, 2005). Disease can be caused by a blockage or interruption of that flow, and acupuncture or acupressure can be used to remove those blockages. In the early 1960s, an American chiropractor named George Goodheart discovered that he could successfully treat physical problems by tapping on acupoints (Adams & Davidson, 2011), and a clinical psychologist named Roger Callahan developed a system of acupoint tapping for psychological problems (Callahan, 2000).

One of Callahan's students, Gary Craig, abbreviated Callahan's system and named it EFT (Craig & Fowlie, 1995). That's the same method we'll practice throughout this book. It's fully described in the current edition of *The EFT Manual* (Church, 2013), though we'll give you enough information in this book for you to use it yourself effectively.

This book also includes a chapter on "The Gentle Techniques" reprinted from *The EFT Manual*. These are three specialized EFT techniques designed for working with trauma. They allow you to process even highly

traumatic events quickly and easily. Though the Gentle Techniques are easy to learn and apply, research and clinical practice have shown that they are phenomenally effective at permanently resolving the symptoms of PTSD.

Your First Experience with EFT: Try It Now

Are you ready to try EFT yourself? I like to show people how to do EFT first, rather than engage in long-winded explanations. When you have your first tangible experience of how fast it can heal a psychological wound, you'll be a believer. There's an old Hermetic saying that goes like this: "For the person who's not had the experience, no explanation is possible. For the person who's had the experience, no explanation is necessary." EFT is like that. Doing it even one time gives you a "felt sense" in your body of the kind of relief it can offer you, even if you're working on a burden you've carried for a long time and believe it's impossible to lift. You'll be surprised at how far and how fast you can heal with EFT.

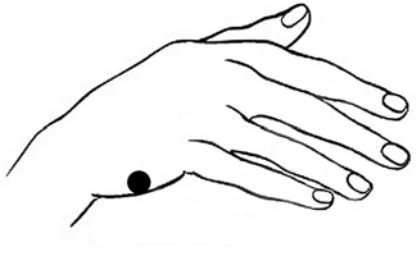
Here's a very simple way to do EFT for the first time that will give you a sense of its potential. It's going to take you less than 2 minutes. I'm going to keep it as simple as possible, and I'm also going to give you a practical tool to measure whether or not EFT is working for you. I'd like you to think about a traumatic memory. Pick one that's safe to work on, one that you know from past experience won't send you into a tailspin. Pick an event that took five minutes or less to occur, and one that you can label with a title. If it were a movie, what would the movie title be?

Rate the severity of your emotional distress on a scale from 0 to 10. Zero indicates no distress whatsoever; you can think about the memory and feel completely calm. Ten indicates emotional agony. In EFT we call this score your SUD or Subjective Units of Distress (Wolpe, 1958). Write down your SUD score here:

Movie Title _____

SUD Before EFT _____

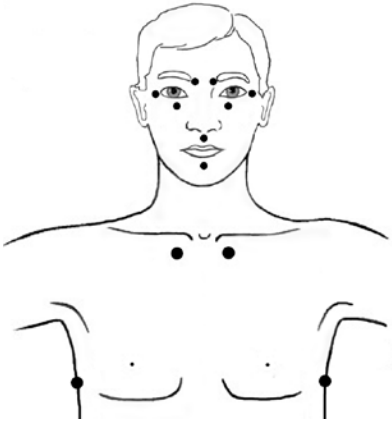
Use the accompanying illustration to locate the first tapping point on the side of your hand. We call this the Karate Chop point. Lightly but firmly, tap there with the fingertips of the other hand while repeating this phrase: "Even though I experienced [movie title], I deeply and completely accept myself." You don't have to believe this statement, since EFT is not dependent on your level of belief. Simply say the words.



Karate Chop (KC) point.

Keep tapping, and repeat that phrase three times.

Then, tap on the following points with two fingers of either hand 7 to 10 times, on either side of the body, while repeating the title of your movie.



EB, SE, UE, UN, Ch, CB and UA points.

After tapping on all these points, tune back in to movie. Rerun it in your mind. Write down your new SUD level here:

SUD After First EFT Sequence _____

The chances are good that your SUD level is much lower than it was before. It may not be at a 0 yet, however, so let's apply EFT once more. While tapping your Karate Chop point, say, "Even though I still have some distress about [movie title], I deeply and completely accept myself." Repeat this two more times while tapping that same point. Then, repeat your movie title while tapping on every point with 2 fingertips. Really tune in to the details of your movie while you do this.

When you're finished, write down your new SUD level:

SUD After Second EFT Sequence _____

The likelihood is that your SUD is now much lower than before. Perhaps it's even down to 0. If it's not entirely gone, no problem, since you've just tried the most elementary form of EFT. As you read Chapter 3 and improve your skills with EFT, you'll get better and better at applying it. If you're like most people who do this simple and quick exercise, you're probably quite surprised by how fast your emotional pain diminished. This can encourage you to read further, and start to unlock the many deep healing benefits of EFT.

In the next part of this chapter, we'll look at some of the highlights of research into EFT for PTSD. We'll also discuss the standards for "evidence-based" practices published by the American Psychological Association (APA) and how these apply to EFT research and treatment. These are important and interesting topics, but if you'd like to plunge straight into doing more EFT, then jump to Chapter 3, "How to Do EFT: The Basic Recipe." It will walk you, step by step, through doing EFT yourself.

EFT as an Evidence-Based Practice

What does the phrase "evidence-based" mean, and why is it important? Much of modern medicine is based on solid science, but a surprising amount of it is not. Many medical procedures are performed more out of habit or belief than anything else. One example comes from the practice of knee surgery.

One surgeon wanted to compare the two most popular forms of knee surgery to determine which was best, so he performed a randomized controlled trial (RCT)

pitting one against the other (Moseley, 2002). To control for the placebo effect, in which a patient's belief has a healing influence all by itself, he introduced a third group. This group received sham surgery. They were sedated, wheeled into the operating room, incisions were made in their knees just as if they were receiving a real treatment, and they were then sewn up again.

To his great surprise, the placebo group that received the sham surgery did just as well as the other two groups on most measures. At that time knee surgery was an $11-billion-per-year industry in the United States, but that huge expense was being incurred without any clear scientific support.

In fact, the editor of the prestigious peer-reviewed journal the *New England Journal of Medicine* editorialized that medical journals, rather than purveying sound science, had become "primarily a marketing machine" for Big Pharma which was co-opting "every institution that might stand in its way" (Angell, 2005, p. 336). Richard Horton, editor of the Lancet, wrote: "Journals have devolved into information laundering operations for the pharmaceutical industry" (Horton, 2004). When you compare the possible benefits of the treatments they promote against the harm they do and the side effects, Franz Ingelfinger, another editor of the *New England Journal of Medicine* said that the balance is about zero (Ingelfinger, 1977). This is why it's important to determine that any proposed treatment has scientific merit before implementing it.

Clinical EFT

EFT for PTSD and the other books in this series are companions to *The EFT Manual* (Church, 2013). You'll find EFT's fundamental method, called the Basic Recipe, described in detail in Chapter 3 of this book. That's the same form of EFT described in *The EFT Manual,* and the one you just tried from the instructions in this chapter. That form of EFT was used in all the studies cited here, and since it's been validated by much research, we call it Clinical EFT. There are many variants of EFT in the marketplace, but the only one that is backed by many years of scientific study is Clinical EFT. That's why if you do EFT as described in this book and *The EFT Manual,* you can have the confidence of knowing you're using the exact same method that's been proven to work in that whole large body of research.

Clinical EFT will train you to ask the kinds of probing questions that Brad Scott asked the firefighter when they were getting nowhere tapping on the recent deaths. Whenever I hear someone say, "I used EFT and it didn't work," deeper inquiry reveals that they'd used a superficial variant of EFT, and not Clinical EFT. When I then use the full arsenal of tools we offer in Clinical EFT on the problem, even though EFT "didn't work" in the past, the client usually has a massive breakthrough.

The books in this EFT series also abide by the standards of the American Psychological Association (APA) in terms of style, ethics, and proof. The Clinical Psychology division of the APA (Division 12) published standards for "empirically validated treatments"

(Chambless & Hollon, 1998)—"APA standards," for short—and EFT meets those standards for a wide variety of psychological problems including anxiety, depression, PTSD, and phobias (Feinstein, 2012).

The Evidence for EFT Treatment of PTSD

Several studies of EFT have shown it to be very effective for PTSD. A hospital in Britain's NHS (National Health Service) compared EFT to Eye Movement Desensitization and Reprocessing (EMDR), another excellent method (Karatzias et al., 2011). Both EMDR and EFT were also compared to treatment as usual (TAU). The investigators found that patients receiving either EFT or EMDR recovered in an average of four sessions, while those receiving TAU did not get better at all. This was a startling result since most conventional treatments for PTSD take much longer than four sessions and are not nearly as successful.

This result was echoed in another RCT comparing TAU with TAU plus EFT. It found that 86% of veterans recovered from PTSD after six sessions, with 80% still recovered when followed up in 3 and 6 months (Church, Hawk, et al., 2013). The drop in PTSD symptoms was a dramatic 64%. This study was replicated by an independent research team (Geronilla, McWilliams, & Clond, 2014), with essentially the same results. The APA standards require two RCTs in order for a treatment to qualify as "empirically validated" and, at this point, EFT has more than met that burden of proof.

Data from the Church, Hawk, et al. (2013) study were also examined in greater detail by other researchers in order to glean other useful information about how to best bring EFT to veterans. It was found that 67% of veterans recover after six telephone EFT sessions, but 91% recover after in-person EFT sessions, showing that the latter are significantly more effective (Hartung & Stein, 2012). The work of licensed mental health professionals was compared to EFT delivered by life coaches and found to be slightly more effective (Stein & Brooks, 2011). Pain, depression, and anxiety all improved when PTSD was healed (Church, 2014). In tandem with PTSD, symptoms of TBI (traumatic brain injury) dropped by an average of 41% even though TBI was not the target of treatment (Church & Palmer-Hoffman, 2014).

In addition to these RCTs, there have been several studies in which EFT was used with groups of traumatized people. Their symptom levels were measured before and after treatment, rather than comparing them to a second group. Though not as strong evidence as RCTs, these studies nevertheless show the difference in the PTSD symptoms of sufferers before and after treatment.

In a pilot study of 11 veterans and family members at a 5-day retreat, they showed significant drops in PTSD symptoms (Church, 2010). Another pilot study was the precursor to the RCT summarized previously, and it was there that six sessions of EFT were found to permanently reduce PTSD symptoms in veterans (Church, Geronilla, & Dinter, 2009).

One large-scale study looked at the PTSD levels of 218 veterans and their spouses before and after attending a healing retreat (Church & Brooks, 2014). As part of the program they received 4 mornings of EFT. Each retreat lasted 7 days, and six retreats were conducted. They all showed the same pattern. An average of 82% of veterans had high or "clinical" PTSD symptom levels before the retreat; afterward, this number had dropped to just 28%. Additionally, 29% of the spouses also had PTSD going into the retreat, but only 4% afterward.

Another study offered 2 days of EFT training to 77 victims of the 2010 Haiti earthquake (Gurret, Caufour, Palmer-Hoffman, & Church, 2012). Before treatment, 62% of them tested positive for PTSD, while afterward 0% did. These studies show that EFT is effective when delivered in groups, as well as in individual counseling sessions.

Applying EFT

Now that you understand that Clinical EFT is an "evidence-based" practice, and that it is supported by a strong research base, in the rest of the book I'm going to show you what the symptoms of PTSD look like and how you can address them with EFT. I'll show you how EFT is applied in the most desperate of traumatic events, such as war and natural disasters, as well as personal disasters such as auto accidents, assault, and child abuse.

I'll walk you through the neurological changes that occur in the brains of PTSD sufferers, so you can see how it's not just a psychological problem, but a physical

one too. I'll encourage you with lots of stories by people who've healed from PTSD and by therapists and life coaches who worked with them. We'll explore the differences between working with PTSD and working with other mental health conditions.

By the time you've read this book you'll have a comprehensive picture of how to use EFT for PTSD, and what's happening in the body and mind when you tap. You'll also have become involved with the large community of people and resources committed to clearing the human suffering caused by the condition. You'll have a resource you can share with professionals such as your doctor or therapist, and will have experienced the healing possible with these methods. You'll join the thousands of others who are determined to bring EFT to millions of suffering people, and share the vision of a world in which PTSD is as archaic a disease as typhoid or cholera. You'll get a glimpse of the possibility of the end of PTSD, not just for you and your loved ones, but also for the whole world. Thanks for joining me on this amazing journey!

2

About Posttraumatic Stress Disorder

Pervasive Psychological Trauma

Psychological trauma is widespread. While news reports focus on the high levels of PTSD found in veterans, trauma is far more prevalent in the civilian population than most people realize. Since the wars in Iraq and Afghanistan began in 2001, far more Americans have died at the hands of family members than have been killed in the Middle East. Women are twice as likely to be victims of domestic violence than they are to get breast cancer (van der Kolk, 2014, p. 348).

Much of this violence affects children. According to a report by the U.S. Department of Health and Human Services, 60% of older children had witnessed or experienced victimization in the past year. Close to half had experienced physical assault, and 25% had witnessed domestic or community violence (U.S. Department of Health and Human Services, 2012). Twice as many children are killed by firearms as by cancer.

Incest, the sexual abuse of a child by a family member, was once thought to be uncommon. In 1975, an authoritative source, the *Comprehensive Textbook of Psychiatry,* concluded that, "incest is extremely rare, and does not occur in more than 1 out of 1.1 million people" (Freedman, Kaplan & Sadock, 1975). However, recent estimates are that one in 10 boys has been molested, and one in five girls, usually by a family member (Gorey & Leslie, 1997).

It can take a surprisingly "minor" negative experience to traumatize a child. In a series of studies called the Still Face Experiments, Harvard psychiatrist Edward Tronick examined the effect on a child of a parent's emotional withdrawal (Tronick, Als, Adamson, Wise, & Brazelton, 1979; Tronick, 1989). He instructed the mothers of young babies around 6 months old to keep their faces impassive instead of interacting with their babies.

Figure 1. The Still Face Experiments.

When the mothers maintained a still face for a short period, instead of the constant interplay of facial expressions that we unconsciously but continuously use for connection, the babies noticed immediately. If the babies failed to receive facial communication within a minute or

two, they became increasingly agitated, then distressed, and finally began to flop around in uncontrolled desperation. While the mother did nothing to harm the baby, the mere withdrawal of connection was sufficient to produce extreme emotional distress.

The phenomenon is not just emotional, it's physiological too. When their emotions are disrupted, their bodies are disrupted as well. "Babies cannot regulate their own emotional states, much less the changes in heart rate, hormone levels, and nervous system activity that accompany emotions" (van der Kolk, 2014, p. 112). They are dependent on cues from the adults around them to produce this regulation. Bonding produces a steady heart rate and a low level of stress hormones. An interruption of connection with their caregivers produces spikes in stress hormones, as well as dysregulation of the nervous system and heart rhythm.

Tronick's work showed that it doesn't take being beaten or abused to affect a young child; the simple absence of emotionally reassuring cues from a caregiver can be traumatic. Sometimes people in my live EFT Level 1 and 2 workshops say, "I grew up in a pretty normal family, I had a happy childhood. So why am I so screwed up?" The answer is that it can take a surprisingly small disconnect from mother or father to upset a young child.

Attachment: Secure vs. Disorganized

Children whose needs are attended to by their caregivers develop what's called "secure attachment." Babies communicate their distress directly and immediately

when they feel uncomfortable physical sensations such as being hungry, feeling upset, being wet, and feeling tired. When their cries are heard and their needs met, they associate the communication of their needs with getting them met. They learn that it's safe and natural to be tuned in to your body, and aware of your needs.

Figure 2. Secure attachment.

Children who don't receive consistent nurturing, or who are ignored or even abused, don't develop secure attachment. Instead they may become anxiously or ambivalently attached, as the parent from whom they're expecting care is unavailable or even a source of pain. They don't develop emotional or physical attunement with those around them, missing the cues that allow people to bond.

Children who are routinely abused or neglected can develop "disorganized attachment." They learn that their

crying, pleading, and upset will not produce positive results from their caregiver. No amount of distress they exhibit in response to the physical and emotional signals they're getting from their body (hungry, tired, wet) is sufficient to get their needs met. The caregiver is not attuned to the baby's needs.

The child develops a "deep emotional learning" that his or her needs don't matter. The parent, for the baby the source of nurturing, is also the source of pain. For the baby, the parent is the source of survival, even if they're being abused. According to van der Kolk, "Terror increases the need for attachment, even if the source of the comfort is also the source of terror" (2014, p. 133).

When they're punished for simply expressing their needs, babies begin to associate having needs with pain. They shut down the impulses they're receiving from their bodies in an attempt to avoid punishment. They often develop a sense that there's something wrong with them. No amount of distress they express is enough to make the abuse stop. They become helpless in the face of abuse. This learning is taking place at a body level, long before they develop words, the ability to think consciously, and the brain structures required for cognitive interaction. This type of learning is occurring at the level of the cells, in the deepest layers of the body.

When their cries are heard and their needs met, babies develop a set of beliefs about the world and attitudes toward nurturing. The first way we learn about self-care is though the care we receive from others, which becomes the template for our subsequent worldview.

When children with disorganized attachment become adults, they may have little concept of self-care, and even become self-harming. They believe their needs don't matter, and that their existence is meaningless. They are chronically out of touch with their own bodies.

The Long-Term Results of Disorganized Attachment

The results of disorganized attachment and the dysfunctional lessons learned by such children show up in adulthood. In a 20-year longitudinal study of girls who had been sexually abused, the effects were found to be pervasive (Trickett, Noll, & Putnam, 2011). They had high levels of depression, obesity, dissociation, major illness, and self-mutilation. They entered puberty an average of 18 months earlier than non-abused girls. They had cognitive deficits and abnormal levels of certain hormones. Early in puberty, their levels of androstenedione and testosterone, hormones that stimulate libido, were three to five times higher. Their cortisol responses to stressful events were lower than normal, indicating that their bodies had adapted biochemically to high levels of emotional stress.

Another longitudinal study followed children for 30 years, all the way into adulthood (Sroufe, Egeland, Carlson, & Collins, 2010). It found the quality of early attachment to be the major predictor of adolescent and adult behavior. Children with disorganized attachment were chronically anxious. Not having learned the "dance of attunement" early in life, as adolescents they were

unable to regulate their own emotions and had high levels of frustration, aggression, and disruptive behavior.

Figure 3. Traumatized child.

They exhibited a lack of empathy for the emotional distress of other people. They failed to develop healthy relationships with peers, caregivers, and teachers. By late adolescence, half of the children in the study had been diagnosed with a mental health condition, and had low levels of resilience, the ability to bounce back after an adverse experience.

Trauma Is Physical as Well as Psychological

Psychological trauma is not a merely psychological problem; it affects the body at the most fundamental levels. The most basic need of any organism is survival. Other needs, such as digestion, reproduction, and self-actualization, cannot be met if the organism fails to survive. The survival mechanisms of our bodies resulted in the fight-flight-freeze response, and you'll be surprised at

how many parts of your life and behavior are driven by this response.

Because survival is essential, when an animal is under threat, every other need and function is recruited to ensure survival. Those physical systems that can assist (such as circulation and respiration) have their functions altered to support survival. Those that are unable to assist (such as reproduction and digestion) are simply shut down. An immediate threat produces a radical reorganization of cellular resources down to the molecular level.

The body's survival functions are controlled by the autonomic nervous system (ANS). At the top of the spinal cord is the hindbrain, the pinnacle of the ANS. It handles all the functions a newborn baby can perform, including excretion, respiration, circulation, and digestion. It continues to perform these functions for adults without any conscious input from the rest of the brain. They happen automatically; for the fancy word "autonomic," you can substitute the straightforward word "automatic" since all these functions are taken care of in a healthy body automatically, without any necessity for conscious thought.

The ANS has two distinct parts: the sympathetic and the parasympathetic. The sympathetic nervous system (SNS) is responsible for handling stress, while the parasympathetic nervous system (PNS) is responsible for relaxation. When we're stressed, the sympathetic half of the ANS is dominant, and when we're relaxed, the parasympathetic part takes over.

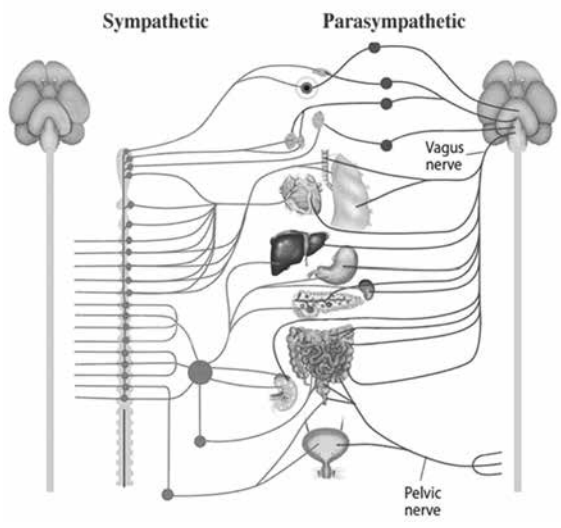


Figure 4. The sympathetic and the parasympathetic nervous systems.

Take a look at the diagram of the sympathetic and parasympathetic systems (Fig. 4), and notice the radiating nerves. These nerves connect with your heart, your lungs, your eyes, your mouth, your digestive system, your liver, your bladder, and your reproductive organs. They're the conductor of the symphony, telling all the systems of your body what to do at any given moment. When you're relaxed, they sound the all-clear, and all your systems go into repair and rejuvenation mode. When you're stressed, they sound the alarm, and all your systems get ready for fight or flight. You can readily observe some of the organs regulated by the ANS when you reflect on the following types of events:

- You have to give a speech. Your mouth dries up. You have knots in your stomach.
- You remember the death of a loved one. You cry.
- You've been working on a project so intently that you forget everything else, and suddenly you're finished and you relax. You have to go to the bathroom.
- Your spouse brings up a dinnertime topic that upsets you. Your food curdles in your stomach.
- A person you despise enters the room. You bristle.

This stress-regulation system has worked so well, for so many millennia, that it's scarcely changed at all. The dinosaurs, extinct for 65 million years, had much the same ANS as you do. So do their descendants, today's lizards and birds. When you're a fetus growing in the womb, this part of your body develops first, just as it does in a salamander or an elephant. The reason that it's changed so little over millions of years is that it was perfected all those ages ago and it's simply so good at doing its job that Mother Nature has had no cause to tinker with it since.

Stress Is Hormonal as Well as Neurological

Neurotransmitters and hormones are molecules that work together with your ANS as a component of the system that signals your body to be stressed or relaxed. The two most important stress hormones are adrenaline and cortisol. Though there are others, I like to use cortisol as shorthand for the whole range of neurochemicals used in

response to stress, because it can be measured in saliva and blood and there are many studies showing the stimuli that elevate its levels.

As a convenient shorthand for a relaxation hormone, I use DHEA (dehydroepiandrosterone), because it's your main relaxation hormone. Your body uses it for cell repair and rejuvenation, as well as signaling between cells. When you're stressed, your body makes more cortisol; when relaxed, more DHEA. These hormones move in concert with your SNS and PNS. When your SNS says go into flight or flight, you make lots of cortisol, and shut down production of DHEA. When your SNS says relax, you make lots of DHEA and reduce your production of cortisol. Understanding these cycles is vital to understanding your overall health because of all the body systems—digestion, circulation, reproduction, respiration,

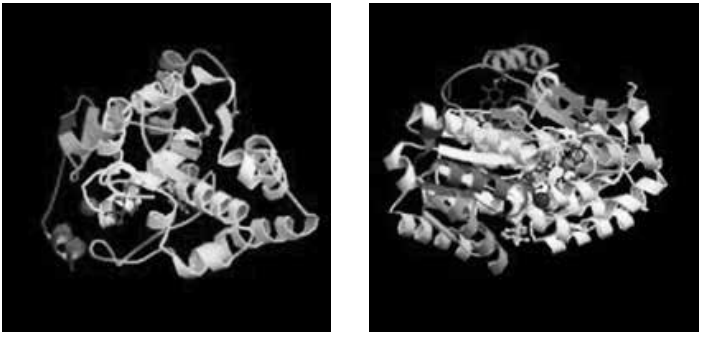


Figure 5. DHEA (l.) and cortisol (r.) molecules. Notice how similar the two molecules appear. That is because the body synthesizes them from the same precursors.

and immunity—that are affected by your level of stress and relaxation.

So if this system is so perfectly adapted to ensuring your survival, how can it be a problem? It's not a problem when children are raised with secure attachment, with periods of slightly elevated stress followed by relaxation and renewed attunement. The dance of attunement develops in the child a somatic or body-based sense of how to manage stress long before it develops the ability to think or reason. These abilities extend to its adult set of competencies.

When children are raised with disorganized attachment, however, they are in high stress mode most of the time. They live with their SNS on continual high alert. They adapt to having the neurophysiology of stress as their "set point." Stress is normal, while relaxation is not. As adults, they tend to have high levels of cortisol and low levels of DHEA. If they are highly stressed for long periods of time, they may deplete their stocks of both hormones, leading to the loss of energy characterized as "adrenal burnout." They may also develop abnormal patterns of cortisol secretion, such as low levels in the morning when cortisol is normally high to give you the energy to start your day, and high cortisol at night. This leads to insomnia and nightmares.

High stress is linked to virtually every type of disease. Studies show chronically high cortisol to be linked to loss of bone density, loss of muscle mass, increased skin wrinkling, cognitive decline, the inability to turn short-term into long-term memories, and many diseases.

While a cortisol spike is adaptive when it gives us the shot of juice required to evade danger, it takes a terrible toll on the body if the alarm system is turned on continuously. In traumatized people, it spikes higher and faster, and remains at a high level long after the danger has passed.

Your Body Can't Tell the Difference

Here's the real problem, and how this affects you whether you were raised with secure attachment, disorganized attachment, or anything in between: Your body can't tell the difference between a stressful thought and a stressful event. The subjective stressful thought that's "all in your mind" sends the same signal to your body that an actual objective threat to life and limb produces. Your cortisol shoots up within seconds. Your SNS goes into high alert. All your body systems are affected. You can do this by thought alone, without anything wrong in your environment. You've produced all the neurophysiology of

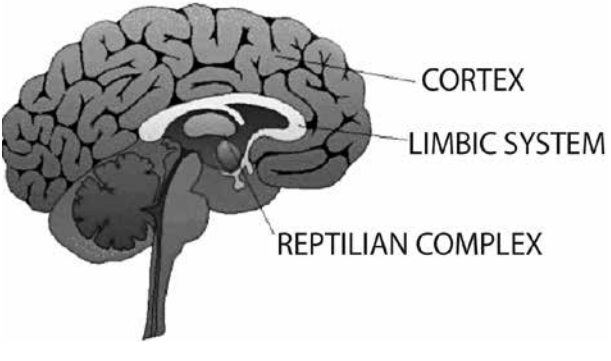


Figure 6. The triune brain.

stress in your body while having no objective reason to be on high alert.

The human brain has two layers above the reptilian survival system of the ANS. The midbrain or limbic system has many functions, and evolved later. It's the mammalian part of the brain, and it governs emotions. Mammals can feel emotionally in ways that reptiles cannot. They are able to navigate complex webs of social interaction. During the first 18 months after birth, the limbic system is the fastest-growing part of the brain, as the child is learning attachment and attunement. The lessons learned during this phase literally become part of the

Figure 7. Identifying threatening cues is essential to survival.

permanent wiring of the brain, which makes them so hard to change later in life.

Your midbrain also has two structures crucial to the emotional part of the stress response: the hippocampus and the amygdala. The hippocampus is like a military historian. Its job is to examine information coming in from the environment. If it finds a match between a piece of incoming information ("man wearing red shirt") and a previous threat ("I was beaten up when I was *7* by a bully in a red shirt"), it identifies a potential threat in the here and now.

The amygdala is like the fire alarm of the body. Once the hippocampus has made a positive match, and the match is confirmed by other structures in the brain, the amygdala's job is to sound the alarm, telling the SNS to go into fight-or-flight mode.

Driven to Distraction by Your Cortex

Above the mammalian brain is the primate brain, the cortex. This is the part of the brain that monkeys, dolphins, and other highly evolved species possess. It is largest in human beings, who have abilities that non-primates like dogs and cats do not. We're capable of abstract thought. We can reflect on the past, make projections about the future, and create highly structured mental products based on mathematics and poetry. We have language and song. All these are products of the cortex, which in evolutionary terms is the youngest part of the brain.

Where the cortex works against us is when we think abstract thoughts that drive strong emotion and trigger the fight-or-flight response. The thought, "John slammed my ideas at the staff meeting" isn't a threat to your survival, but if you're ruminating on it for hours over the weekend when you should be relaxing, you're driving your cortisol up and your DHEA down. You're engaging your SNS and negating all the cell repair and restoration processes governed by your PNS. There's no threat to your survival—the event happened several days before—yet you're still sending stress signals to your body.

The brain is constantly adding new connections, a process known as "neurogenesis." It's also pruning old unused circuits. While the ability of the brain to rewire itself in response to experience (this ability is called "neuroplasticity") is of great assistance when we're learning a new skill, it works against us when the circuits we're improving are those associated with stress. Stressed brains reinforce the neural pathways dedicated to carrying stress-related signals, at the expense of the brain regions responsible for memory, learning, and making high-quality executive decisions. Researchers have noted that PTSD symptoms often get worse over time, as neuroplasticity builds up the circuits of stress (Vasterling & Brewin, 2005). In an essay for the journal *Energy Psychology,* I call this "the dark side of neural plasticity" (Church, 2012).

Bringing the Traumatized Brain Back Online

The brains of people with PTSD do not process information as effectively as normal brains. The parts of the brain are unable to work in synchrony. Normally, all the regions of the brain work together when presented with incoming information. Figure 13 shows the difference (van der Kolk, 2014, p. 311). The PTSD brain has difficulty coordinating its activity in order to process the incoming information, and bring coherent focus to bear on the immediate situation.

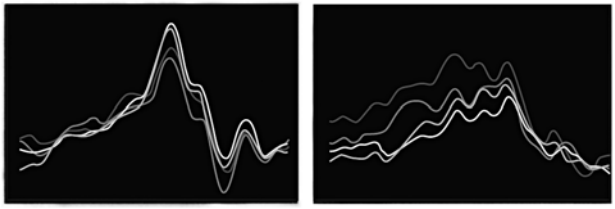


Figure 8. The brains of normal subjects coordinate their functioning to process information (left). The brains of PTSD sufferers aren't able to function in synchrony (right).

A team of EFT volunteers went to Haiti two years after the 2010 earthquake devastated the country and orphaned 250,000 children. They made a 7-minute video showing their work. You can see it at Haiti.EFTuniverse.com. One of the most touching scenes shows "Amelie," a girl who was 8 years old at the time of the earthquake. She and her mother were inside a building that collapsed. Her mother was killed, the girl survived, but it was two days before rescuers pulled Amelie from the rubble.

Imagine being trapped and immobilized with your mother's dead body for that length of time. Amelie was so traumatized that she had not spoken a single word in the two years since the earthquake. This is a classic example of the deactivation of Broca's area in the brain. She didn't socialize, laugh, or play with other children her age, indicating that her limbic brain was shut down.

Figure 9. Survivor of the 2010 earthquake in Haiti.

Under the guidance of the EFT practitioners, Amelie taps and starts telling a toy teddy bear how sad she is. After two days, the video shows her laughing and talking and playing with the other kids like a normal child of her age, as Amelie's entire brain comes back online and returns to synchrony.

In one large-scale study I performed with a group of colleagues, we analyzed the PTSD levels of 218 veterans and their spouses (Church & Brooks, 2014). Subjects attended one of six week-long retreats. Being married or coupled was one of the requirements of attendance. They did EFT for their PTSD symptoms in small groups. At

the start of the retreats, 83% of the veterans met the criteria for a PTSD diagnosis. By the end, just 7 days later, only 28% did. When they were followed up 6 weeks later, they had maintained their gains ($p < .001$).

Living with a veteran with PTSD can by itself be traumatizing, and lead to "transferred PTSD." This phenomenon was evident in the spouses of the veterans in the study. When they began the retreat, 29% of the spouses also met the clinical criteria for PTSD. However, they had results similar to those of their partners. On follow-up, only 4% had diagnosable levels of PTSD. Each of the six retreats was analyzed separately, as though it were a small study by itself. The healing trajectory of participants was the same regardless of which retreat they attended, showing that the results were similar across the different groups. Being with a supportive partner can make a huge difference in the healing process. Social support reinforces the recovery of an individual.

Figure 10. Tapping session with a veteran.

While we might classify "physiological" or "medical" symptoms as a physical diagnosis, and "psychological" conditions such as phobias, depression, and PTSD as "mental" ones, they are often two sides of the same coin. Van der Kolk (2014, p. 188) notes that older WWII veterans are more comfortable couching their distress in terms of physical symptoms, while younger veterans of the recent Middle East wars are more comfortable describing their mental health challenges, but these are simply different frames of reference for the experience of traumatization.

Trauma that results from early childhood experiences with caregivers is harder to treat than trauma acquired in adulthood (van der Kolk, 2014, p. 210). For the veteran, the source of trauma is a clearly defined enemy. For the child, the source of trauma is a caregiver, a person who the child expects will nurture and care for them. This violation of expectations at a time when the brain is forming produces very deep emotional wounding. Van der Kolk calls this "developmental trauma," and argues that since it has unique characteristics, it should be included as a new diagnostic category in the DSM.

EFT is unique among therapeutic approaches in that it actually makes deliberate and systematic use of dissociation in the healing process. EFT recognizes that dissociation can perform a protective function. Chapter 6 describes EFT's three "Gentle Techniques" for working on events so traumatic they cannot be approached in ordinary states of consciousness. The three Gentle Techniques allow the client to dissociate just enough to feel safe, while also tapping. This creates enough psycho-

logical distance from the event to allow the client to begin the healing process. The felt sense of safety engendered by the Gentle Techniques quickly demonstrates to the client that it may be possible to reduce the degree of emotional triggering around the event. With this encouragement, the client then approaches the event at his or her own pace, dissociating less and less until he or she is able to tap on the memory itself without dissociation.

Stroking Your Inner Dog

Tapping on acupuncture points soothes the body. It sends a signal of safety to the emotional brain that counteracts the signal of stress coming from a traumatic memory. MRI studies show that acupuncture shuts down the brain's fear centers, regulating an overstimulated amygdala (Napadow et al., 2007; Hui et al., 2005; Fang et al., 2009). It speaks to the parts of the brain that respond to touch and other sensory input, not to the neocortex in which reason resides. For this reason I call it "stroking your inner dog."

Acupressure helps dissociated people feel safe in their bodies, sometimes for the first time. This provides them with a base of security from which they can begin the healing process, and start to unpack their trauma capsules. Randomized controlled trials show that as well as successfully treating PTSD symptoms in traumatized veterans, EFT reduces the symptoms of "somatization," the array of baffling physical ailments that have no medically discernible cause (Church, Hawk, et al., 2013; Geronilla, McWilliams, & Clond, 2014).

One of the three Gentle Techniques—Chasing the Pain—is specifically aimed at physical symptoms and is effective for clients who are uncomfortable talking about their emotions, but are very ready to describe their physical symptoms. Veterans in general and older veterans in particular are notoriously reluctant to discuss their mental health problems, but will readily describe physical symptoms: these are "medical" and "objective" and don't carry the perceived stigma that "emotional problems" do (van der Kolk, 2014, p. 19).

PTSD, Anxiety, and Depression as Chemical Imbalances in the Brain

Over the past century, physiologists have made many exciting discoveries about the body. The first hormone to be discovered was adrenaline (epinephrine) in 1900. In

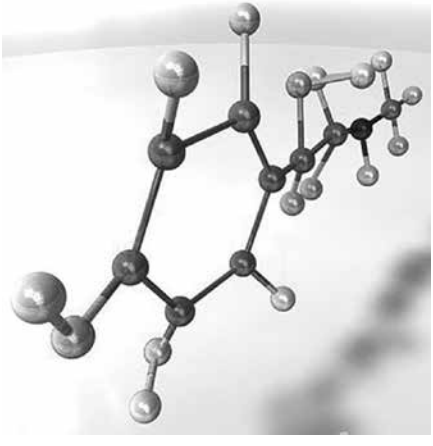


Figure 11. Adrenaline molecule.

1921, the first neurotransmitter, acetylcholine, was identified. As more of these essential protein molecules were discovered, and their link to human emotions understood, the race to find drugs that might modify their action began.

Pharmaceutical drugs have produced unparalleled improvements in human health in the past 150 years. Imagine a world before antibiotics or painkillers. However, because drugs have worked spectacularly well for certain conditions such as infectious diseases, the drug model has come to dominate medicine, displacing personal self-efficacy and non-pharmacological approaches such as psychotherapy and natural remedies.

My wife and I saw a 20-something woman tanning in the sun a few years back. "Aren't you afraid of skin cancer?" my wife asked her. She shrugged and said, "Soon the doctors will have a pill that will handle it." She was so confident in as-yet-undiscovered miracle cures that she was willing to bet her health on them, abdicating responsibility for her own well-being in the present, and handing it over to imaginary doctors of the future who would produce a magical cure for the results of her own self-neglect.

The biomedical model has come to dominate the popular imagination, as well as the professions of medicine and psychology. In the mid 20th century, psychotherapy was the way most mental illness was treated. Today psychotherapy has been displaced by drug therapies. Human brain function is regarded as a matter of chemistry rather than choice or behavior. A standard textbook declared: "The cause of mental illness is now considered an aber-

ration of the brain, a chemical imbalance" (Deacon & Lickel, 2009).

However, the limits of this approach have become painfully obvious. Today prescription painkillers kill more people each year than guns or car accidents (van der Kolk, 2014, p. 349). While the cautious and appropriate prescribing of antidepressants and other psychotropic drugs can help certain patients, these drugs are being prescribed far more broadly than the scientific evidence supports.

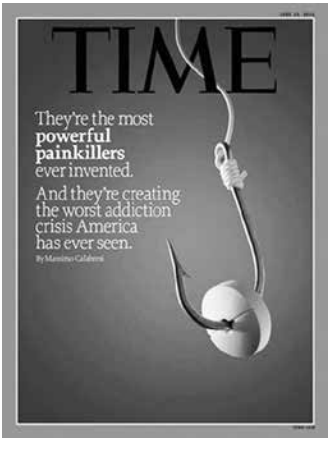


Figure 12. *Time* magazine—the painful cost of painkillers.

Because the number of prescriptions written for antidepressant drugs has soared, you would imagine that rates of depression should have plummeted. The opposite is true. The number of people diagnosed with depression has doubled in the past decade (Hidaka, 2012). In his book *Anatomy of an Epidemic,* medical journalist Robert

Whitaker outlines the research showing that many of these drugs have serious side effects, and that long-term use of antidepressants may actually cause chronic depression by disrupting the normal functioning of the brain (Whitaker, 2011).

The VA Could Have Remediated PTSD for Half the Cost of One Drug

During the first decade of this century, the U.S. Veterans Administration (VA) and the Department of Defense (DOD) spent $791 million on a drug called risperidone (Tal, 2013). Initially touted as a treatment for PTSD, a clinical trial published in the *Journal of the American Medical Association* eventually showed that it was no more effective than a placebo, an inert comparison pill (Krystal et al., 2011).

Because they offer the allure of a quick fix, writing prescriptions for PTSD and other mental health problems such as anxiety and depression has become the

Top drug sales

Top drug sales estimates for military and retail pharmacies, 2002-2011

Brand	Combined sales
Lipitor	$1,317,000,000
Plavix	$1,317,000,000
Advair	$1,148,000,000
Nexium	$983,000,000
Singulair	$973,000,000
Celebrex	$903,000,000
Zocor	$781,000,000
Prevacid	$670,000,000
Aciphex	$664,000,000
Actos	$613,000,000
Enbrel	$594,000,000
Effexor	$494,000,000
Fosamax	$481,000,000
Ambien	$417,000,000
Zyrtec	$413,000,000

Sources: TRICARE; Defense Logistics Agency

Figure 13. Military sales of top prescription drugs.

norm in the military. Meanwhile, the Pentagon and VA rebuffed repeated attempts to evaluate EFT, an evidence-based behavioral treatment, for PTSD. EFT studies were presented to the VA as early as 2008, when Senator Carl Levin, chair of the Senate Veterans Affairs Committee, wrote a personal letter to Secretary for Veterans Affairs Eric Shinseki, enclosing an early outcome study showing veterans recovering from PTSD after EFT treatment (Church, Geronilla, & Dinter, 2009).

Three other congressmen wrote to Shinseki again in 2010, enclosing more research and further evidence. They proposed seven simple and cost-free steps to help veterans gain access to EFT, such as circulating copies of clinical trials to VA mental health professionals. None of these steps was taken. In September 2013, Congressman Tim Ryan (D-Ohio) wrote another letter to Secretary Shinseki, this time advocating EFT on the basis of 11 clinical trials. Like all the other letters, this one was rebuffed, with the VA declining to examine the evidence, perform its own research, refer patients to the Veterans Stress Project, or take any other action to get EFT to suffering veterans.

The costs of such failure are staggering. Each veteran with PTSD costs an estimated $1.4 million to treat (Kanter, 2007). The cumulative cost to society of treating both the remaining 400,000 Vietnam veterans with PTSD, as well as the estimated 500,000 PTSD-afflicted veterans of the recent Middle East wars, exceeds $1 trillion (Church, 2014). By way of contrast, the cost of six sessions with an EFT practitioner for every one of these veterans comes to $300 million. For less than half of what

the military spent on risperidone, it could have purchased this effective and safe behavioral treatment for every veteran with PTSD. If the results were as good as those in the studies, nearly nine out of 10 of those veterans would be PTSD-free today.

Meanwhile, the prescription drug machine rolls on. In 2012, according to an investigative report in the *American-Statesman,* "the Pentagon spent more on pills, injections and vaccines than it did on Black Hawk helicopters, Abrams tanks, Hercules C-130 cargo planes and Patriot missiles—combined" (Smith, 2012).

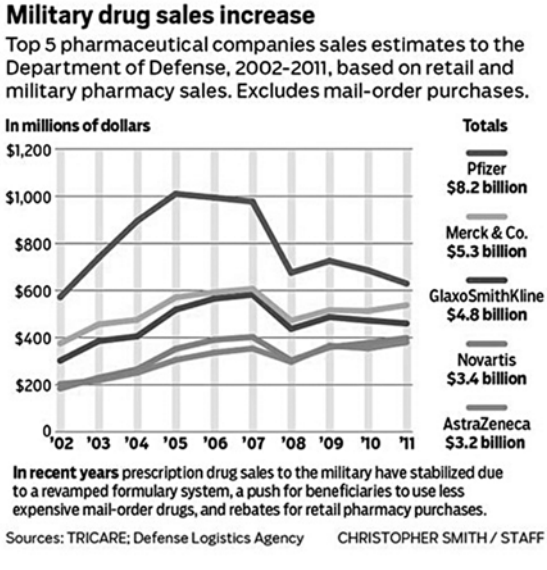


Figure 14. Increasing revenue to Big Pharma from military sales.

The widespread belief that there's a pill for everything leads both individuals and governments to seek medical solutions to problems instead of empowered personal action. Although our modern society has an impressive array of medical resources, they are not a substitute for self-care. Responsibility for our well-being rests on our own shoulders as individuals, and is not in the hands of our doctors and psychologists. They're there to support our health, not to magically fix us. Through practices such as yoga, mindfulness, relaxation, and EFT, we can regulate our own physiology, including neurotransmitters, hormones, genes and brain waves. No prescription is required.

When we practice responsible self-care, we're far less likely to require medical intervention. Postsurgical recovery times for fit and healthy people are much shorter. When we do have a crisis that requires medical intervention, we have a marvelous array of modern drugs and surgical techniques available to us, giving us the best of both worlds. Self-care and good medicine are both essential; neither excludes the other.

While working with WWII veterans with "shell shock," pioneering psychiatrist Joseph Wolpe discovered that diaphragmatic breathing was effective and developed the simple yet elegant scale that we use in EFT, called Subjective Units of Distress or SUD (Wolpe, 1958). People were instructed to rate their degree of emotional distress from 0, no distress, to 10, maximum possible distress, when remembering the event. A drop in the score meant that the treatment was succeeding.

Staying in the Body

Getting SUD scores every few minutes also encourages clients to stay tuned in to their bodies. Van der Kolk regards getting veterans "back into their bodies" to be one of the hallmarks of successful treatment (2014, p. 47). Another is bringing them back into the present moment. When they were traumatized, they learned how to escape the horror they were experiencing by dissociating, with awareness escaping from the here and now. Effective treatments put them back in touch with their physical sensations, and the reality of what's happening in the present.

Acupoint tapping wasn't practiced in the West during Wolpe's time, but EFT still uses the same SUD testing method, the same focus on the present moment, and the same body awareness. What Wolpe's diaphragmatic breathing and EFT have in common is that they keep the client from dissociating by maintaining a firm focus on the physical present. Other effective therapies such as Eye Movement Desensitization and Reprocessing (EMDR) and Somatic Experiencing do the same thing. They keep the client in the present moment, and in their body, while recalling a past trauma.

In all these therapeutic approaches, the immediate experience of physical safety effectively counterconditions the old stress response. Even though the traumatized person is thinking of a stressful event, these body-focused approaches remind them that they're safe in the here and now. This breaks the association in the brain's limbic system between the stressful memory and the fight-or-flight

response. Once the association is broken one time, it's usually broken for good. That's why long-term studies that follow participants long after their EFT therapy sessions are over find that their recovery is permanent.

Talk therapy can be effective, and some approaches such as cognitive behavior therapy have a long track record of success. For traumatized people, however, talking about their issues can retraumatize them. In a large study of veterans diagnosed with PTSD and enrolled in a care program at a VA hospital, nine out of 10 did not complete the required program (Seal et al., 2010). We've heard this from many veterans who've been through our six-session EFT program at the Veterans Stress Project after dropping out of VA programs. They make statements like "Talking about the war just made me feel worse." In a study of cognitive behavioral therapy for PTSD, half the participants did not respond to treatment (Monson et al., 2006), in contrast to EFT studies that show upward of 80% veterans permanently rehabilitated.

Reducing Stress Hormones

In 2005, I had a striking experience while watching a group of trainee EFT practitioners. I was astonished at their incompetence. They were missing obvious physical cues from their clients, such as deep sighs and relaxing shoulders. They were missing verbal cues such as changes in psychological perspective, forgiveness, and acceptance. They didn't know the exact location of the acupressure points, and they were often tapping far off the mark. They

were trying too hard to bring SUD scores down, instead of following and validating the client's experience. They were applying EFT techniques mechanically rather than organically. All of these mistakes were understandable on their learning curve.

What struck me forcibly, however, was that despite the shortcomings of the practitioners, the clients were getting results. They weren't getting results as good as they might have obtained from working with an expert practitioner, but they were getting results far better than those I'd seen in my earlier training in Gestalt therapy.

As I watched clients physically relax, I wondered what might be happening invisibly inside their bodies to their stress hormones. To answer this research question, I designed a study to examine their cortisol levels. With colleagues from the California Pacific Medical Center and the University of Arizona, I conducted the first study that examined both psychological conditions such as anxiety and depression, and cortisol levels before and after EFT (Church, Yount, & Brooks, 2012).

The study was ambitious and took several years to complete. It was conducted at five integrative medical clinics in California, and eventually included 83 subjects. It was a triple-blind randomized controlled trial, the highest standard of scientific proof. The results were remarkable, and the study was published in a prestigious journal, the oldest peer-reviewed psychiatry journal in North America.

We assessed subjects' mental health, and also measured their cortisol, before and after a single therapy

session. One group received EFT, a second group talk therapy, and a third group simply rested. Psychological symptoms such as anxiety and depression declined in the talk therapy and rest groups, but they dropped more than twice as much in the EFT group. Cortisol dropped quickly and significantly. The study showed that EFT was having an effect inside the body.

Regulating Gene Expression

With some of the same colleagues, I began a randomized controlled trial examining changes in gene expression in veterans after 10 EFT sessions (Church, Yount, Rachlin, Fox, & Nelms, 2015). Again, the study was difficult to fund and accomplish, and took many years to complete. But the results were worthwhile, and echoed the physical effects we'd identified in the cortisol study. We found that genes associated with inflammation in the body were downregulated, like turning down the dimmer switch on a lamp. Genes associated with immunity were upregulated, or turned up. The psychological symptoms of PTSD dropped by over 50%, echoing the results of earlier studies (Church, Hawk, et al., 2013; Geronilla, McWilliams, & Clond, 2014). This study shows that EFT is an epigenetic intervention, affecting the body at the most basic level of molecular biology, the DNA.

Many studies have now linked emotional nurturing to gene expression. Stress-regulation genes are turned on in the brains of newborn rats that are attentively licked and groomed by their mothers (Bagot, et al., 2012). When the brains of schizophrenics who have committed suicide are

compared with the brains of mentally healthy people who died in accidents, the genes responsible for regulating stress are found to be turned off. The DNA is still there, but it's been inactivated by the stressful experiences of early childhood (Poulter et al., 2008; McGowan et al., 2008).

The link between physical and emotional symptoms has been understood for over a century. In his book *The Traumatic Neuroses of War*, psychiatrist Abram Kardiner (1941) described his observations of WWI veterans. Even people who had been highly functional before the war became detached (dissociated) and hypervigilant. He understood that PTSD is a condition of the body as much as the mind, writing that the "nucleus," or center of traumatic stress was a "physioneurosis" that took root in the body. Though science in Kardiner's time knew nothing of gene regulation, the physical basis of PTSD was observed by him and many other clinical professionals treating veterans and other traumatized populations.

Eye Movements Link Brain and Body

Another compelling link between brain and body was discovered after WWII. A British ophthalmologist published a book in which he noted that veterans had erratic eye movements (Traquair, 1944). A study confirming the link between eye movements and PTSD involved a collaboration between a psychiatrist and an ophthalmologist checking refs (Tym, Beaumont, & Lioulios, 2009). They studied 100 patients, and found that those with PTSD had persistent difficulty maintaining the stability of their peripheral vision while contemplating a traumatic event.

After successful psychiatric treatment, however, the eye fluttering disappeared, and they were able to recall the event without either emotional distress or visual impairment. According to another published report, 90% of psychiatric patients have these visual anomalies (Tym, Dyck, & McGrath, 2000).

Neuroscientists don't know exactly why this association between traumatic memories and eye movements occurs. It may be linked to the ability of the brain to process a disturbing event. The limbic system contains structures that are responsible for turning short-term memories into long-term ones. This memory processing function is impaired in patients suffering from PTSD. This theory is discussed in an article in Scientific American (Rodriguez, 2012). It summarizes how research into EMDR, a therapy that is as effective as EFT for PTSD (Karatzias et al., 2011), demonstrates that the eye movements are an active ingredient of the therapy and not an inert placebo (Shapiro, 1989).

EFT uses a protocol for eye movements called the 9 Gamut Procedure (Callahan, 1985). It involves 9 actions performed while tapping a point called the "Gamut" point located on the Triple Warmer acupuncture meridian on the back of the hand. It includes eye movements, tapping, humming, and counting. The client moves his or her eyes slowly around a big circle at the extreme periphery of vision. The 9 Gamut Procedure is believed to engage parts of the brain involved in the nonverbal resolution of trauma. Other Clinical EFT Techniques such as the Floor to Ceiling Eye Roll (Feldenkrais, 1984) also use eye movements to reduce emotional distress. The developers

of neuro-linguistic programming (NLP) believed that lateral eye movements correlate with aspects of experience such as internal dialog, kinesthetic sensations, and imagery (Bandler & Grinder, 1979). States such as REM sleep when the dreaming brain is in theta mode demonstrate that eye movements are part of the way the brain processes information.

I use the 9 Gamut Procedure often during live coaching calls. While most EFT techniques focus on neutralizing particular traumatizing events, the 9 Gamut Procedure is effective at neutralizing a whole class of events simultaneously. If I'm working with a man whose father beat him often as a child, I'll use this technique on all the beatings instead of focusing on a particular beating. If I'm working with a woman who was sexually molested as a child, I'll use the 9 Gamut on the group of adverse experiences rather than identifying particular events. Usually, the SUD score of such clients for the entire class of events drops slowly over the course of half an hour. This approach is much more efficient than working on the events one by one. Once you're finished with the 9 Gamut, you can test the effect of your work by having the client focus on a single event and determining whether it's been neutralized.

When I'm working with clients in workshops, I watch their eyes closely. The erratic peripheral vision movements noted by Traquair are readily observable by the coach (though not by the client). Frequently clients will move their eyes through every quadrant of the visual field except for one. They will consistently skip the same quad-

rant, like the hands of a clock going smoothly all the way around the face, but skipping between 3 and 6 o'clock. Once EFT has decreased the degree of distress, they no longer skip that quadrant, and their eye movements are smooth all the way around the field of peripheral vision.

Clinical experience by thousands of EFT practitioners working with tens of thousands of clients has shown the 9 Gamut Procedure to be effective even when the other parts of EFT's Basic Recipe are unable to provide resolution to a problem. While the cognitive parts of EFT may reach the reasoning brain operating in an alpha-beta mode, it's likely that the 9 Gamut technique is reaching the nonverbal and preverbal parts of the brain. These are operating in that theta-delta superlearning trance. Clients receiving a long and thorough session with eye movements appear to go into a trance state. The practitioner then introduces Reminder Phrases from the traumatic memory. While these might produce high emotion before treatment, these triggers are removed by the 9 Gamut. The client still has the memory, but it no longer evokes strong emotion. In this way the 9 Gamut is able to treat memory tracks laid down in a preverbal state early in childhood, as well as those produced by severely traumatic adult experiences.

Memory Reconsolidation and Extinction

Until the early 2000s, the prevailing view in neuroscience was that, once an experience had been installed in long-term memory, it was difficult or impossible to change (Ecker, Ticic, & Hulley, 2012). Beliefs about the self and

the world formed in early childhood through strong negative emotional associations were "locked into the brain by extraordinary durable synapses" (Ecker et al., p 3). They were believed to persist throughout the person's entire life. These memories were said to be "consolidated" into the neural network.

Then a series of studies with animals showed that, under certain conditions, even long-consolidated memories might become "labile," or malleable, and susceptible to change. This led to the discovery that "a consolidated memory can return…to a labile, sensitive state—in which it can be modified, strengthened, changed or even erased!" (Nader, 2003, p. 65). Clinicians began to ask if this model might be applied to psychology, allowing, for instance, PTSD patients to undo the strongly conditioned and consolidated memories that had traumatized them so deeply.

Certain treatment sequences seem to allow the brain to revise even long-consolidated beliefs. These protocols have now been precisely delineated. Ecker, Ticic, &

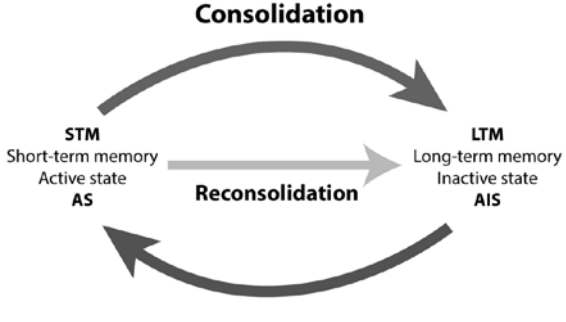


Figure 15. Memory reconsolidation.

Hulley (2012) call this the "transformation sequence," and break it into three interrelated stages:

1. Vivid re-exposure to the memory or experience must occur.
2. At the same time, a contradictory experience or memory ("juxtaposition experience") must be activated.
3. Several repetitions of the juxtaposition experience may be necessary in order for the new worldview to overwrite the old one.

Whether or not a therapist is aware of these three steps, Ecker and colleagues (2012) believe they are present in every successful therapeutic encounter. For this reason, Ecker calls this model a "meta-conceptualization" that applies to any type of therapy, not just to one school or technique.

Death in Vietnam: Joe's Story

A striking example of memory reconsolidation comes from "Joe," a disabled veteran with PTSD and multiple physical symptoms. During one the six free sessions he received from his EFT practitioner after enrolling in the Veteran's Stress Project, Joe shared one of his most disturbing intrusive memories. His best friend, Ted, had been killed by a sniper in Vietnam. Ted and Joe used to go on patrol each day. Joe usually walked on the right, while Ted walked on the left. The day Ted was shot, they happened to have reversed positions, with Joe on the left. For over 40 years, Joe had suffered from "survivor's

guilt," and his narrative about the event was "The bullet was meant for me."

After tapping as he described each component of the memory, Joe had a sudden cognitive shift, saying, "I'm realizing that, like I would have died for him, Ted would have died for me. He would have wanted to take the bullet for me, just like I thought I should have taken the bullet for him." This new narrative led Joe to feel a sense of resolution around the event, and he was no longer troubled by it. His SUD score went to 0.

How EFT Applies the Three-Step Formula

In Step 1 of the formula identified by Ecker and colleagues (2012), Joe vividly recalled all the details of that day. EFT uses a Setup Statement to focus the client on the traumatic event, and a Reminder Phrase to keep attention on the event. Not only is the whole event recalled; Clinical EFT practitioners are trained to focus the client on all the details of the event, as well as sensory input that might be encoded in the trauma capsule. They might ask the client, "What did you see… taste… feel… touch… smell." An expert practitioner will mine the details of the event for every channel in which trauma might be encoded.

In Step 2, a contradictory experience is introduced in the form of tapping on acupoints. The soothing experience of tapping is juxtaposed with the upsetting memory being vividly recalled. The 9 Gamut Procedure may be added to the protocol. Limbic deactivation is occurring, PTSD-linked genes are being downregulated, and cortisol

Figure 16. EFT session.

is being lowered, at the same time that the traumatic event is being held in memory.

In Step 3, repetition, the client taps repeatedly till the SUD score is reduced. This may take more than one round of EFT tapping. If the SUD level is not down to 0 after the first round, repeated rounds are performed. The 9 Gamut may be performed until the client's eyes are able to move smoothly through every degree of the peripheral visual field. The practitioner may dig for further details, and often clients access memory fragments they had forgotten or dissociated from before. An experienced Clinical EFT practitioner will keep asking questions until it is apparent that all the details and manifestations of the trauma have been extinguished.

At that point, the practitioner might instruct the client to make the details even more vivid or dramatic, in an effort to determine if the emotional charge of the memory has truly been extinguished. Once the client reports a

SUD score of 0 for even the most troubling aspects of the memory, and can later recall the memory while remaining at a 0 SUD level, the work of memory reconsolidation and extinction is done.

These memories are not "extinguished" in the sense of being erased. What is extinguished is the emotional distress associated with the memory. This can be tested days, weeks, or months after the event by asking the client to remember the event again. The memory is usually still intact but without the emotional charge. The client may evidence a cognitive shift with statements like "It was awful, but I grew stronger through the experience" or "My dad was abused by his dad much worse than he abused me." Cognitive shifts might take the form of changes in visual perspective. The person might now perceive themselves as witnessing the event rather than being part of the scene. The event may come into sharp focus. Or the opposite may happen, with a previously clear image now becoming blurry.

In this way, EFT is a short and efficient therapy for producing memory reconsolidation and the extinction of emotional cues, even in extreme trauma cases such as those resulting from the earthquake in Haiti and the genocide in Rwanda, and long-standing PTSD such as that found in Vietnam veterans. Feinstein (2010), reviewing eight studies examining the effect of acupoint tapping on PTSD, maintains that: "(a) tapping on selected acupoints (b) during imaginal exposure (c) quickly and permanently reduces maladaptive fear responses to traumatic memories and related cues."

The Future of Psychology and Medicine

I believe we are entering a new era in psychology and medicine as dramatic as the elimination of most infectious diseases at the start of the 20th century. Research shows that body-based approaches such as EFT and EMDR have the ability to remediate most mental health conditions in just a few sessions. Treatment time frames range from one session for phobias (Wells, Polglase, Andrews, Carrington, & Baker, 2003) to 10 sessions for difficult diagnoses such as PTSD (Church, Yount, Rachlin, Fox, & Nelms, 2015).

Figure 17. EFT session.

Imagine these therapies being available as front-line medical care. Imagine every veteran having access to EFT, and international initiatives to offer EFT to large groups of traumatized people. Imagine a society as dedicated to eliminating these mental health problems as we were to eliminating infectious disease. Imagine depres-

sion, anxiety, phobias and PTSD becoming as rare as polio, cholera, or typhoid fever. The infectious disease revolution was accomplished quickly, and the mental health revolution might occur just as quickly.

Imagine if future generations of children are raised by parents who have healed their own traumatic histories. Imagine if every child with test anxiety, social phobia, or public speaking anxiety had the tools of energy psychology at his or her fingertips. Imagine teams of mental health professionals treating survivors of natural and human-caused disasters, alleviating the suffering that would otherwise occur.

This is all very possible. As a society, we now have the tools to accomplish this, just as we accomplished the eradication of many infectious diseases generations ago. Having the tools, we now need the vision and the will to use them effectively. I believe that collectively we may well make this decision, resulting in a future society very different than the one we live in today. As we tap away our own individual traumatization, we will enjoy happier and more balanced lives. As we offer these methods to others, we contribute to a happier and more balanced society. Our children and grandchildren will thank us, just as we thank the heroes who gave us a world free of most of the diseases from which previous generations suffered. We are part of a large social movement that I believe will result in a future very much better than our past.