To: To Whom It May Concern  
Re: Emotional Freedom Technique (EFT) In Military Settings

Greetings from Fort Hood. I am the Director of the Warrior Combat Stress Reset Program (WCSRP) at CRDAMC. WCSRP is the intensive outpatient specialty program for PTSD at Fort Hood, in place since August 2008, with about 950 Graduates. WCSRP is a comprehensive multi-modal treatment program in a day-treatment setting, using a massed and synergistic set of interventions, including trauma-focused psychological techniques and CAM modalities. Emotional Freedom Technique (EFT) is a core modality among many. It is taught as a self-help tool and used in 1:1 therapy.

I have been a clinical psychologist since 1970, serving in the USAF at the end of the Vietnam War, where I first encountered combat PTSD. I have been involved in the Energy Psychology movement and EFT for many years and know most of the proponents, teachers and researchers. I have observed the development of EFT and its relatives in the Energy Psychology world. I am on the Research Task Force of the Association for a Comprehensive Energy Psychology (ACEP). I am aware of how the recently resolved ACEP dispute with the American Psychological Association over CEU’s happened. I think the current status of EFT and the other “tapping” procedures is not so negative as many skeptical professionals imagine.

EFT is a key element in an amazingly complex social/psychological phenomenon, largely happening outside of organized psychology and behavioral health care, although there are many therapists who use it in their practices. Most of them report they let go of their initial skepticism because of observed clinical results. There are more recent and better designed studies too. Getting an acupressure or energy psychology study published in a mainline journal that you can find on Medline is not easy so the other alternative venues are a better source of case studies or small studies. The search is worth it since the data is fascinating. I am sure you have been sent the various reviews so I will not re-iterate this topic here.

My current take is that EFT is the simplest of a number of effective techniques derived from the older Callahan Technique (or TFT) hybrid of imagery and acupressure. I have done both TFT and EFT for maybe 15 years and am still astounded at what they can often provide in terms of rapid symptom relief. These tools are really confusing to see in action. Soldiers are very practical – they quickly detect BS and discard things that don’t have value for them. Once they try EFT for something distressing, they quickly say something like “this stuff is weird but it WORKS!”

I cannot explain how EFT works and I have tried every explanation I know of. It just works faster and better than anything else I know of for some types of emotional issues. My personal threshold for applying a therapy is that I have to have evidence of safety and efficacy. EFT clears both. Explanation of mechanisms will have to wait.

EFT is an evolving therapy within the wider Energy Psychology movement (with a serious professional organization (ACEP) and a well-designed certification process). Energy Psychology (and EFT) is also a burgeoning multifaceted self-help movement with a growing lay audience of people who use it and advocate its application for all manner of human issues. You Tube has EFT videos by the dozens, of varying adequacy, and EFT fan groups
are on Facebook. It is unprecedented in my 40+-year career to see this type of spread of a psychological tool, even more so than meditation in the 1960's and 1970's.

In any case, our use of EFT at WCSRP as both a clinical tool and a self-help technique is quite positive. Soldiers generally like it (after their initial skeptical view) and they use it constantly in managing their acute reactivity to triggers and other upsets. Those who take to it most strongly have produced some remarkable results with triggers, nightmares and traumatic memories. I would hate to have to do what we do here for moderate to severe PTSD soldiers without it in our tool kit.

We have a research project on the drawing board to go the IRB that would essentially replicate the best pilot study of EFT with Veterans. It will likely be after the current Program Evaluation analysis. Among other developments, an EFT expert is working with the New Hampshire National Guard and there are lots of EFT therapists quietly tapping away in VA settings.

Here are the answers to some basic questions:

1.) How many patients have been treated with acupoint tapping at WCSRP?

We have had about 950 graduates of the Warrior Combat Stress Reset Program (WCSRP). All have been taught EFT as a self-help technique for stress management. A sub-set have used it in 1:1 therapy sessions with their individual therapists, focused on trauma memories and used in conjunction with other trauma focused therapy techniques. The WCSRP treatment package has a large protocol of treatments used in a synergistic 3-week day-treatment model. I retrospectively wish I had tagged the files of the intense EFT users for a sub-analysis.

2.) How have the soldiers responded to the technique?

Most of our soldiers find the "tapping therapy" useful in a variety of ways - recovering from acute triggering events for example, as well as quieting physical reactions after exposure interventions and in-vivo trials. EFT is really amazing in dealing with phobias and phobic-like triggered responses. In 1:1 therapy sessions, EFT often produces dramatic and fast drops in distress while working through "Top 10" trauma memories. The results are dramatic and apparently permanent. Most of the time, we need to make a couple of passes at an index event in subsequent sessions to clear up the different aspects of the event (somatic, emotional, images, meaning). None the less, the results are faster, more effective and less traumatic than anything else I know how to do, including CBT and EMDR. The successful soldiers often use descriptions like "... it is now just a bad memory, not a trauma...". Then they can talk their way through the events and use other tools to clarify its meaning and impact.

3.) Have there been negative or adverse reactions?

In a word, "No"... Since it is a trauma-focused exposure-like tool, you generally get increased distress as you tackle an index event but you can "tap" on the anticipatory anxiety and fear responses and get some initial decrease before you even get to the heart of the story. Remember we do this in the context of a comprehensive multi-modal process that is very powerful in decreasing arousal and providing supportive interventions. Some soldiers do not get immediate responses, often due to readiness issues. We let them go and use some other approach.

4.) Is it used as an adjunctive therapy or as a primary therapy?

That is an "N/A" in our setting where every soldier enters a multi-modal comprehensive milieu. EFT is used in a context that contains many other treatment modalities so it is an adjunct for some goals (relaxation, in-vivo exposure) and a primary in other goals (reducing distress from trauma memories). However, EFT is a potent tool
as a "lead" technique in a package with an individual patient who is not in the integrative program. EFT seems to have some unique impact results with trauma event memories that soldiers value.

Like most psychotherapies, this tool is rarely applied as a single modality. The only exception in my experience was in dealing with medical patients with "needle phobia" when faced with an IV team or a phlebotomist. As a single quick intervention, it seemed to be roughly 75% effective in single sessions with dozens of simple phobia cases.

5.) Do you believe that tapping could benefit an outpatient psychiatric clinic where PTSD is not the primary diagnosis?

I have used "tapping therapies" in almost 20 years of cases of all kinds as a medical/health psychologist. As the accumulated literature suggests, EFT and the related "tapping" therapies are most useful in anxiety disorders but applicable in most cases where emotional distress is a prime symptom. In addition, physical disorders, including chronic pain, often respond, presumably due to the reduction in aggravating autonomic response (fear of the pain or other symptoms makes things worse). Also remember that trauma events are a background psychosomatic component in many, many kinds of presenting psychological and physical problems. Remember also that restoring self-efficacy is a key in improved function in many patients. Self-applied EFT is very useful in this key component of therapy response. Also, one of my Medication Providers uses EFT as an adjunct to medication since, in his experience, it decreases side-effects and improves anti-anxiety and sleep effects. That suggests another interesting study.

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