Thought Field Therapy – not something that the cat dragged in?

If research continues to document the speed and power of Thought Field Therapy, it would be unethical to hold back access to this form of help, writes Atle Dyregrov.

USE OF HANDS: In Thought Field Therapy, one has the client focus on the specific traumatic image or problem while tapping acupressure points, writes Atle Dyregrov in this opinion piece. Photo: DraconianRain / Flickr.

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Abstract

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In 2009, I published a small paper in the journal of the Norwegian Psychological Association (Dyregrov, 2009) pointing out that despite its rather meek academic merits, I found Thought Field Therapy very useful for dealing with problems originating from trauma or loss. I wanted to make clinicians interested in learning more about the method. I mentioned the scepticism that I first encountered when I introduced Eye Movement Desensitization and Reprocessing to Scandinavian clinicians in the early 1990s (Dyregrov, 1993), and how over time this method has come to be regarded as one of the most efficient and well-documented post-traumatic therapies (i.e., Chen et al., 2014).

Following the publishing of the 2009 article, a colleague (Lindgren, 2009) wrote in the aforementioned journal about how unscientific the method was, and suggested that if we were to be open to Thought Field Therapy we had to be open to everything. Approving Thought Field Therapy, he wrote, meant allowing anyone to call themselves a psychologist. It was as if I had proposed to embark on something professionally unethical. I should say that Lindgren was frank enough to write what many others thought, but were more careful of saying explicitly.

As a consequence of the debate, the Norwegian Psychological Association withdrew its support for Thought Field Therapy courses, stating that they should not support training in methods without scientific documentation (Norsk Psykologforening, 2009).

Over the years that have elapsed, I have continued to use this method, not always with success, but I have certainly often found it a very useful tool at my disposal. Before describing some newer empirical research, I will present a case study to illustrate its usefulness. Having had many clients who have had the same good benefits as the man in the presented case, I hope that curiosity coupled with a critical look at the evidence will encourage clinicians to make use of the techniques described.

Minimizing distress

A man well into old age is referred from the local emergency clinic. He was at home when his wife died in an accident a year previously. He found his wife in a position that was very strongly imprinted on his mind, resulting in strong intrusive images from her death. In addition, he felt strong guilt over not having prevented her death. It was clear that the intrusiveness of the experience caused debilitating symptoms for him and he suffered so severely that he found he could not go on living. Already in the first session, I asked if he was willing to let me try a method that I had found to be helpful for others. He was an academic and I explained that there was little solid evidence to back up the usefulness of the method.

I also said that it would take little time to see if it was of use to him, and that if it worked it could reduce his distress. He consented and Thought Field Therapy was used for around five minutes

with an instant drop in his subjective unit of distress (SUD), a crude measure that reflects the subjective experience of distress related to an experience or emotion.

Following Thought Field Therapy, he could recall (see in his mind's eye) his finding of his wife without distress at all. He was also taught some simple self-help strategies (see Dyregrov, 2014) that he could employ until the next session, if he continued to be bothered by the experience.

When he returned for the next session, he said that not only had what we did in the previous session stopped the intrusive images, but also that the comet's hale of various other reactions tied to the experience of finding his wife had also evaporated. Although his situation had greatly improved by using Thought Field Therapy, he continued to feel guilty and for this symptom, Thought Field Therapy did not prove very efficient. Use of other more cognitively based techniques (Kubany & Manke, 1995) improved this situation somewhat, but his ruminative thoughts about guilt surfaced from time to time. Because of his age, most of his friends were dead, and we kept in contact with infrequent sessions over a long period until his death.

In Thought Field Therapy, one has the client focus on the specific traumatic image or problem while tapping acupressure points. Change can come quickly, and in my years of using the method, I have seen no side-effects. In my clinical work, I will often use it early on, either with single-event traumas or with post-traumatic complications in bereavement. To reduce distress, I will even use Thought Field Therapy in the first session, accompanied by advice on self-help methods to use until the next session. If Thought Field Therapy does not work, I will use Eye Movement Desensitization and Reprocessing or Cognitive Behavioural Techniques/exposure-based therapy depending on the presenting problems. In choosing a therapeutic procedure, I will prioritize methods that minimize distress in clients and at the same time are the least time-consuming.

A sceptical attitude

With Eye Movement Desensitization and Reprocessing, it took many years from Francine Shapiro's description (Shapiro, 1989a, b) of the method until it was recognized as a well-established treatment method. During this process, it was ridiculed and criticized. It remains a method surrounded by discussions (see, for example, Lilienfeld, 2011), and, at least in Scandinavian countries, it is still not part of most clinician's repertoire.

Thought Field Therapy, understandably, is even met with more scepticism. As clinicians, however, we cannot let the strangeness of a technique, a feature that Eye Movement Desensitization and Reprocessing, and Thought Field Therapy have in common, determine a method's benefit for us. Recently I lectured psychology students near the end of their studies and they were all very sceptical, having heard from other psychologists that this technique belongs in the domain of charlatanism. Seeing a video of a woman who was «cured» quickly of intrusive memories from viewing a dead body that had made her very dysfunctional for six weeks shook their preconceptions, but many remained in great doubt. To my mind, a critical mind should be nurtured among students, but if preconceptions are limiting their ability to acknowledge new things, it may also be a problem.

Church, Feinstein, Palmer-Hoffman, Stein, and Tranguch (2014), especially, discuss resistance to the method in the area of trauma, my own specialty field. They note that nothing in the training or background of most physicians or researchers prepares them to understand how acupressure can play a role in overcoming psychological disorders, or the speed and power of the results. It may be that the concepts used to describe the changes, i.e., the theories from energy psychology that are offered as explanations of the changes, are so remote from usual western concepts that this puts clinicians off. However, the method may work for very different reasons than those proposed by the method's originators.

I may also speculate that the popularity of Thought Field Therapy among lay people, with the fact that Thought Field Therapy therapists without any clinical background set up shop and advertise in the media (as is the case in Norway), leads not only to scepticism among mental health professionals but also to fear of being seen as unprofessional if they use the method. From my perspective, if the method is effective, mental health professionals need to learn the method and practice it. However, by possessing a mental health background, we can assure that those in need of more help than this method can offer can also access this alternative help. I fear that non-trained persons using the method, although they may not cause harm by use of the method, may cause harm because they do not recognize (or sufficiently understand) those in need of more help.

The empirical basis of Thought Field Therapy

Without doing a thorough review, I would like to point out that the evidence base for Thought Field Therapy, or its variant, Emotional Freedom Techniques, is mounting quickly. Recently, Church and co-workers (2014) discussed the «translational gap», that is the time between when a method is proven efficacious and when it becomes available to patients who could benefit from it. After first discussing and describing the American Psychological Association Division 12 (the Society of Clinical Psychology) criteria for an «empirically supported treatment», the authors go on to discuss Emotional Freedom Technique's efficacy according to these criteria.

They present their findings in the highly prestigious *Journal of Nervous and Mental Disease*. They conclude that the Emotional Freedom Technique, or what they term «clinical EFT» to distinguish it from all the variants of tapping techniques available, meets the standards as an «efficacious» or «probably efficacious» treatment for four conditions on Division 12's list: anxiety, depression, phobias, and PTSD. They list 15 studies that meet the seven essential Division criteria. In another paper, Church (2013) reviews Emotional Freedom Technique's extensive experience base with 23 randomized controlled studies and 17 within-subjects studies. Some of these studies are presented in the following.

Church, Piña, Reategui, and Brooks (2012) randomized 16 adolescents (12 to 17 years of age) into two groups. The experimental group received a single session of Emotional Freedom Technique while the other group was a waiting-list control group. While the waiting-list group did not improve, the post-test scores on the Impact of Event Scale (measured one month later) in the intervention group had improved to the point where all had a nonclinical total score and symptom subscale scores (intrusion and avoidance). The study has its limitations (i.e., there was no comparison with an active intervention control group, the sample was small, there was no long-term follow-up, and results were obtained by self-report).

In another small study with nine military veterans and two of their family members (Church, 2010), the Emotional Freedom Technique was provided in sessions over five days and a time-series, within-subjects, repeated measures design was used to assess effects. Statistically significant improvements were found and were upheld at 30 and 90-day follow-up meetings (and follow-up data were available for over a year for seven persons). After use of the Emotional Freedom Technique, no person scored positive for PTSD and their distress had decreased significantly. Similar methodological limitations as raised for the Church et al. (2012) study are valid here, as well.

Karatzias and co-workers (2011) conducted a study in Great Britain of the Emotional Freedom Technique comparing it with Eye Movement Desensitization and Reprocessing. They randomized 46 participants to two groups and assessed them with various measures, including the Clinician-Administered PTSD Scale, the PTSD checklist, the Hospital Anxiety and Depression Scale, and Satisfaction with life scale, at baseline and then again after an eight-week waiting period. Two blind assessments were conducted at post-treatment and 3-month follow-up.

The results showed the two treatments to be equally effective with similar effect sizes, though a higher proportion of participants achieved a clinically significant change with Eye Movement Desensitization and Reprocessing. Still, sample size was small, dropout rates were rather high, and larger studies are needed. The authors state, «Nevertheless, the fact that EFT has produced

significant pre-post-treatment effects comparable with those of a well-established intervention such as EMDR indicates that certain processes and components within the EFT protocol facilitate recovery from trauma symptoms» (Karatzias et al., 2011, p. 377).

Sakai, Connolly, and Oas (2010) used Thought Field Therapy in the treatment of 50 orphaned children aged 13 to 18 who were Rwandan genocide survivors. The Child Report of Post-Traumatic Symptoms (CROPS) and the Parent Report of Post-Traumatic Symptoms (PROPS) were used to assess PTS-reactions. The measures provide a cut-off score to indicate PTSD. While 100% scored above the cut-off at pre-treatment, only 6% were above this point at post-treatment, and 8% at the one-year follow-up. Parents perceived reductions in their child with reductions on cut-off scores from 72% (pre-treatment), to 18% (post-treatment), to 16% (one-year follow-up). Although the results from this single session of Thought Field Therapy were very impressive and significant, there was no control group, the therapists that designed the intervention also designed the study, and there are other methodological limitations.

Despite methodological limitations, the results represent mounting evidence that Emotional Freedom Technique/Thought Field Therapy is useful and efficacious in treating trauma.

Causal mechanisms

Thought Field Therapy is denoted as a form of energy psychology, originated by Roger Callahan (see Callahan & Trubo, 2003). Emotional Freedom Technique was derived from this by Gary Craig and has been the method most frequently researched, especially by Dawson Church. The common denominator of these techniques is their reliance on tapping along Chinese energy meridians. Stimulation of acupressure points along these meridians are thought to create energy flow.

As a psychologist and researcher (although my previous research has not been on Thought Field Therapy), I want to understand what happens. I find the energy explanations quite far-fetched (but they may have some truth to them), and I have been looking for explanations more in line with what we know about memory and trauma. There are quite reasonable explanations that have been proposed for the changes that take place during treatment, especially the changes in trauma reactions (Church, 2013; Feinstein, 2008; Ruden, 2007). Among these are:

1. That changes are caused by stimulating acupressure points that reduce the activation signals in the amygdala.
2. That limbic overactivation is reduced by the combination of exposure and stimulating acupressure points.
3. That stimulation alters physiological mechanisms such as cortisol and/or serotonin secretion or brain-state regulation (alterations may affect the protein synthesis in the amygdala necessary for the reconsolidation of memories).

Tapping may also make use of cognitive resources that prevent reconsolidation of memories due to overtaxing working memory. It may be speculated that Thought Field Therapy may have the same effect as shown for Eye Movement Desensitization and Reprocessing; i.e., that it causes an almost instant relaxation response due to activation of cholinergic and inhibition of sympathetic systems (Elofsson, von Scheele, Theorell., & Söndergard, 2008) whilst the traumatic memory is «online». Church, Yount, and Brooks (2012) have shown — in a randomized controlled trial where an Emotional Freedom Technique group were compared to a psychotherapy group receiving a supportive interview, and a non-treatment group — that those in the Emotional Freedom Technique group experienced a significant decrease in cortisol levels. The decrease mirrored an observed improvement in psychological distress.

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These explanations are not offered as truth, but indicate that there are explanations available that can explain the rapid change in the emotional valence of a traumatic memory. It is necessary to distinguish between the theory proposed for the observed changes, and the changes themselves.

Although I sometimes find what I do silly and laughable, and sometimes clients and I laugh together, my primary loyalty is with the client. So far, I am unable to drop a method that so often led to a rapid decrease in problems that have a profound, negative influence on client's lives. If the change is caused by a placebo effect, it is still undoubtedly the most effective technique for capturing such effects that I know of. Notably, it is now an established practice to discuss how placebo effects can best be applied within clinical practice (Bystad, Bystad, & Wynn, 2015).

Conclusion

If research continues to document the speed and power of Thought Field Therapy, it would be unethical to hold back access to this form of help. If, as is my experience, this method represents for many clients a safe and effective method to reduce concrete trauma symptoms, and the method involves less distress for the client than, for example, prolonged exposure, it should be part of every clinician's repertoire. This does not mean that it should not be subjected to more research. There is an urgent need to understand how and why it works, which acupressure points are most effective, and if the algorithms (the sequence of points tapped) are as important as the originators of the technique present them, etc. Such research may mean that we find common denominators between the different «new» therapies introduced for PTSD in later years (so-called alphabet therapies). It might even result in the development of new therapy forms where important elements from several of these therapies are integrated in a more distilled method.

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