

Single Session EFT (Emotional Freedom Techniques) for Stress-Related Symptoms After Motor Vehicle Accidents

Larry Burk, *Healing Imager, Inc., Durham, NC*

Abstract

Motor vehicle accidents (MVA) are a common cause of posttraumatic stress disorder (PTSD). Energy psychology (EP) approaches such as EFT (Emotional Freedom Techniques) are a new form of exposure therapy used to treat PTSD from a variety of different causes. These techniques provide an attractive alternative to more well-established approaches such as cognitive behavioral therapy because of their potential for accelerated healing similar to what has been demonstrated with eye movement desensitization and reprocessing. There are only a few reports in the literature of the use of EP for the

treatment of PTSD resulting from MVA. This clinical report presents 3 case histories documenting the use of single-session EFT for the treatment of acute psychological trauma immediately after a car accident, urticaria as a component of acute stress disorder 2 weeks after a car accident, and PTSD and whiplash syndrome 11 months after a car accident. These cases are discussed in the context of a review of the current literature on PTSD after MVA and are followed by recommendations for future research.

Keywords: motor vehicle accidents, trauma, stress, Emotional Freedom Techniques, EFT

Larry Burk, MD, is President of Healing Imager, Inc., in Durham, NC. He is a musculoskeletal teleradiologist and a medical acupuncture practitioner with a part-time private practice specializing in EFT at www.orientalhealthsolutions.com. He was formerly Associate Professor of Radiology at Duke University School of Medicine and cofounder and Director of Education of the Duke Center for Integrative Medicine. Contact: burk0001@yahoo.com, 907 Broad St, Durham, NC 27705.

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Over 2.3 million people in the United States were injured in 2008 from serious motor vehicle accidents (MVA) (USDOT, 2008). Posttraumatic stress disorder (PTSD) can occur in people involved in up to half of serious car accidents, making MVA a leading cause of PTSD in the general population (Blanchard & Hickling, 2003). Symptoms of traumatic stress include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, and persistent symptoms of increased arousal. Symptoms that last between 2 days and 1 month after the accident can be diagnosed as acute stress disorder (ASD), whereas symptoms that last longer than 1 month can qualify as PTSD (Schupp, 2004).

Cognitive behavioral therapy (CBT) has been shown to be superior to supportive psychotherapy

in the treatment of PTSD after MVA (Blanchard et al., 2003). The Dresden study (Maercker, Zöllner, Menning, Rabe, & Karl, 2006) showed similar results in 8 to 12 sessions that combined well-established CBT techniques (imaginal or in-vivo prolonged exposure and cognitive restructuring) with additional procedures, such as writing assignments, social sharing, and facilitation of posttraumatic growth. Novel approaches such as virtual reality exposure therapy have recently been developed (Beck, Palyo, Winer, Schwagler, & Ang, 2007). Acupuncture has been used for treatment of emotional blocks in whiplash syndrome that resulted in myoclonic shaking, emotional releases, and regression (Greenwood, Leong, & Tan, 1988). Acupuncture has also shown comparable results to CBT for treatment of PTSD in a randomized controlled trial that included a wait list control group (Hollifield, Sinclair-Lian, Warner, & Hammerschlag, 2007).

The features of acupuncture and exposure therapy have been combined in energy psychology (EP) approaches such as EFT (Emotional Freedom Techniques) by subjects self-tapping on acupuncture points during the repetition of a reminder phrase summarizing a traumatic event (Craig, 2008). Subjective units of distress (SUD) that can range from 0 to 10 are assessed before and after

a round of tapping, which usually consists of a generic sequence of eight or more major acupuncture meridian end points on the face, chest, and hands. The reminder phrase may be adjusted on subsequent rounds to address other components of the trauma, which are commonly referred to as “aspects.” EFT can be incorporated into standard individual psychotherapy or taught in groups as a method of self-care. Thousands of lay persons and non-mental health practitioners around the world have learned it, and it thus has potential use as a form of “do-it-yourself” psychological first aid (Craig, 2009).

EFT was shown to be effective in significantly reducing PTSD scores in 11 military veterans and family members during a week of intensive therapy that involved from 10 to 15 individual treatment sessions (Church, 2010). Similar results were obtained in a study of 7 veterans treated with EFT for six sessions each, with all subjects showing statistically significant decreases in PTSD, anxiety, and depression (Church, Geronilla, & Dinter, 2009). The only study of EFT for PTSD following MVA correlated SUD scores and a questionnaire assessing avoidance of driving and riding in a motor vehicle (Swingle, Pulos, & Swingle, 2004). All 9 subjects reported moderate to severe traumatic stress, with an SUD average of 8.3, which was reduced to a statistically significant average of 2.5 after two treatment sessions. A case report that used another EP acupoint tapping technique, negative affect erasing method, resolved nightmares and flashbacks related to a near fatal accident after only one treatment session (Gallo, 2009).

These published studies of rapid and dramatic improvement in PTSD after only a limited number of sessions of EFT or other EP techniques have contributed to the controversy surrounding these approaches in the mainstream psychological community. A randomized controlled trial of EFT versus a wait list in 16 abused adolescents showed a statistically significant reduction in intrusive memories and avoidance symptoms after only one session (Church, Piña, Reategui, & Brooks, 2009). In contrast, one of the strongest studies demonstrating the efficacy of CBT in PTSD showed that 60% of 60 veterans still met the criteria for PTSD after 12 sessions, and 50% demonstrated no improvement at all (Monson et al., 2006). These conflicting results and the unfamiliar claim that tapping on the skin may accelerate the clearing of severe psychological traumas without a well-defined scientific mechanism of action

have created a significant amount of cognitive dissonance among conventionally trained therapists (Feinstein, 2009). The three case histories in this clinical report contribute further support to these claims, as immediate results were again obtained in single-session treatments.

Case 1: First Aid for Immediate Psychological Trauma After Car Accident in One Session

A 39-year-old female laboratory researcher at a major university was in a head-on hit-and-run car accident, which was witnessed by the author. She was stopped in the left-turn lane at an intersection waiting for the light to change when a car turning from the crossing road hit her car in the left front bumper, careened off, and drove away. Her air bag deployed, and she got out of the car within a few minutes. She was calling the police on her cell phone when the author approached to offer assistance. She had minor bleeding from her right hand but no other significant injuries. However, she was visibly shaking and distressed from the acute trauma.

After identifying himself as a physician who treats traumatized patients and volunteering to stay with her until the police arrived, the author offered to help relieve her distress by guiding her through EFT tapping. She began tapping while recounting the experience of seeing the car turn the corner and immediately had an exacerbation of her stress, so she was instructed to stop talking and keep tapping until ready to go on to the next part of the story. She then described the car impact and the air bag expanding. In this way, distress associated with each aspect of the accident was reduced. She tapped until she could tell the whole story without distress. When the police arrived, she was able to describe the situation in a coherent fashion.

The woman then went on to say that she had just had \$1,200 worth of work done on the car that morning in preparation for moving across country to a new laboratory position at another research university in a few days time. A month later the author received a follow-up email expressing gratitude for the timely EFT first aid. She was able to get a new car, drive to her new home, and start her new job without any concerns about the trauma of the car accident. As a basic science researcher, she was unfamiliar with EFT or EP, but she was appreciative of the serendipity of the intervention and its impact on her rapid recovery.

Case 2: Relief of ASD and Urticaria at 2 Weeks Post-Car Accident in One Session

A 21-year-old female college student was enrolled in a stress management class taught by the author at a major university. She complained of severe hives for 2 weeks after a car accident during which she lost control while driving in the rain, spun around several times, and hit a telephone pole. Her studying had been compromised by the constant itching, for which she was prescribed antihistamine medication from the student health clinic. The medicine relieved the hives but made her too drowsy to study, so she quit taking it, and the hives came back. She was quite frustrated with her inability to resolve the situation.

The author had introduced the class to EFT after downloading the EFT manual from the Internet and offered to work with her individually after class as his first trial of EFT. She had only 20 min before her next class but was desperate for relief. She picked “scary car accident” as her reminder phrase, which yielded a 6/10 SUD. Adding “thought I was going to die” made it 8/10. She tapped one round of EFT, and the SUD went down to 4/10. Upon inquiry about other aspects, she then changed the reminder phrase to “guilty about totaling my dad’s car,” which was an 11/10. Another round of tapping reduced the SUD to 2/10 and provided obvious physical signs of relief.

She was instructed not to take any more medication but to continue tapping as needed. She returned to class 2 days later quite pleased to report that she had not had any more hives. She had felt occasional itching, which was relieved by additional tapping. She then mentioned that she had also spontaneously tapped on memories of previous car accidents and had recovered her confidence in driving. These issues had not been mentioned earlier during the brief intervention. At the end of the semester, she reported that she had not had any more hives and that learning EFT had been her most valuable experience of the semester.

Case 3: Relief of PTSD and Whiplash Syndrome 11 Months After Car Accident in One Session

A 52-year-old woman complained of neck stiffness and fear of driving in stop-and-go situations on city streets. She had been rear-ended

while stopped at an intersection 11 months previously. The woman was a college acquaintance of the author. They reconnected for the first time in 32 years at a conference on healing. He observed that she drove very slowly through the city during the conference, far below the speed limit. She had particular difficulty at intersections and had limited range of motion in her neck, which further impaired her driving abilities.

She rated her fear of being rear-ended again at 10/10 SUD and reported having been frozen by fear at the intersection at the time of the accident while watching the oncoming car in her rear-view mirror. She had been taken to the emergency room and treated for a whiplash injury. A round of EFT reduced her SUD to 5/10, but she then experienced a flashback to another car accident 29 years before. That accident had been more serious, resulting in a pneumothorax, rib fractures, and a concussion, as well as the near death of her boyfriend. She described driving and being frozen in the middle of an intersection when a speeding car struck her vehicle on the passenger’s side.

Although she reported losing consciousness after the crash, her memories of being unable to get out of the intersection in the few seconds before the accident were intense, with especially vivid auditory sensations of the oncoming car revving its engine. She tapped several rounds on “being frozen with fear” and then on the stiffness in her neck. Her fear diminished to 0/10, and she was able to drive through the city later that day and stop at intersections without paralyzing fear of being rear-ended. Eight months later she reported that her neck mobility was significantly improved, that her fear was still gone, and that she had gotten one speeding ticket, indicating that she was no longer driving as slowly as before the EFT session.

Discussion

The EP approach in these case reports, EFT, produced effective results for symptoms of stress-related symptoms after MVA in single-session treatments. The treatments were performed informally outside the clinic in everyday situations including a car accident scene, a classroom, and a healing conference. These dramatic results are supported by a growing number of scientific studies of EP in the treatment of PTSD from a variety of causes, including military combat, childhood abuse, and community disasters, some of which

utilized Thought Field Therapy, a precursor of EFT (Feinstein, 2008a). These findings have potential implications for the use of EP techniques for first aid and for the treatment of ASD and PTSD.

Exposure plus CBT is widely accepted as the standard of care for PTSD in conventional psychology, although early studies recommended 10 treatment sessions or more (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998). In contrast, early claims of successfully treating PTSD in one session were made for eye movement desensitization and reprocessing (EMDR), a form of exposure therapy related to EP in utilizing bilateral visual, auditory, or tactile stimulation (Shapiro, 1989). A later PTSD wait-list comparison study of 72 patients, including 17 survivors of MVA, showed slightly better results for EMDR than for CBT, using an average of 4.2 sessions compared with an average of 6.4 sessions of exposure therapy plus cognitive restructuring (Power et al., 2002). A recent study of four sessions of EMDR versus wait list in 27 children with PTSD following MVA showed significant improvement in 75% of the subjects after EMDR compared with no improvement on the wait list (Kemp, Drummond, & McDermott, 2010).

EMDR has moved from the fringes of psychotherapy toward the mainstream due to the publication of a significant number of scientific studies showing its effectiveness for PTSD (Shapiro, 2002). In common with EP, the unfamiliar approach, confusing name, and uncertain mechanism of action of EMDR contributed to conventional therapists resisting its acceptance. Subsequently, theoretical models based in part on brain imaging studies have been developed that offer support for the premise that bilateral stimulation can have an effect on memory processing in the hippocampus and amygdala (Stickgold, 2002). Related models proposed by Lane (2009) for the mechanism of action in EP indicate that acupoint stimulation produces opioids, serotonin, and gamma-aminobutyric acid and regulates cortisol, thereby inducing a relaxation response. This relaxation response counterconditions anxiety and changes memory processing in the midbrain, particularly the amygdala. These data from acupuncture brain imaging studies may assist in greater acceptance of EP in mainstream practice (Napadow et al., 2008).

The connection to acupuncture research is an important one for EP, since acupuncture is now an accepted facet of integrative medicine due in part

to an extensive scientific evidence base (NIH Consensus Development Panel on Acupuncture, 1998). It has been used as an integrative treatment for PTSD in the military at Ft. Bliss Restoration & Resilience Center in Texas (Chang, 2009). Ear acupuncture was used in New York City at St. Vincent's Hospital on 99 survivors of 9/11 and showed a statistically significant reduction in self-rated stress (NADA, 2007). A multidisciplinary pain program utilizing acupuncture in Victoria, British Columbia, achieved a 68% success rate in the treatment of 100 patients with whiplash syndrome, which is also referred to as "accident neurosis" and shares many of the features of PTSD in physical form (Nunn & Greenwood, 1991). If, as Bessel van der Kolk (1994) states, "the body keeps score," perhaps the acupuncture meridians are the scorekeepers and the limbic system is the scoreboard.

First Aid for Psychological Trauma

As illustrated in the first case, EFT has the potential to be used as a form of first aid for immediate trauma. One difference between EFT and EMDR is that EMDR is only taught to licensed mental health professionals, whereas EFT has been taught to a broad variety of healthcare practitioners as well as to lay people. EFT training could be made widely available to paramedics and other first responders to accident scenes and disasters. A related approach using acupressure administered by paramedics was shown to be effective for reducing pain and anxiety in a randomized controlled trial during the transportation of 60 patients after minor trauma (Kober et al., 2002). In stable patients, for whom the emotional trauma may be greater than the physical trauma, EFT could be used in the ambulance, on the battlefield, or at a disaster scene.

Whether or not such early intervention is a good idea is open to debate, as the most widely used conventional method, psychological debriefing has shown disappointing results (McNally, Bryant, & Ehlers, 2003). The motivation to potentially prevent the development of PTSD has obvious merit, but usually only a minority of those who experience acute trauma go on to develop ASD or PTSD. Most people cycle between phases of avoidance and phases of processing in the aftermath of a significant trauma (Pennebaker & Harber, 1993), so any intervention would likely

need to be adapted to the particular coping style of the individual. The rapidity of EP in reducing anxiety may speed up that processing. Lane (2009) has noted that the reduction in anxiety activates different neural networks and gives people greater access to higher levels of cortical thinking to re-evaluate traumas. Perhaps similar to the impact of the addition of EP to exposure therapy, success in psychological debriefing could be increased with the addition of EP. Feinstein (2008b) has documented the effectiveness of EP through systematic observation in several disaster relief circumstances and noted that three international humanitarian relief organizations have adopted EP as a treatment in postdisaster missions.

Acute Stress Disorder

The second case occurred in the context of a group stress management class, which highlights another significant difference between EMDR and EFT: EFT can be easily taught to groups, whereas EMDR is most frequently a component of individual psychotherapy. The ability to offer EFT in a group setting presents obvious advantages in terms of cost-effectiveness, and a group model for CBT has been previously described for PTSD after MVA, which emphasized the potential for building group cohesion and increased social support (Beck & Coffey, 2005). Based on this concept, a randomized controlled trial comparing EFT to CBT for prevention of PTSD could be designed by recruiting patients with ASD from hospital trauma wards to attend outpatient groups after discharge.

This case also focused on a physical manifestation of ASD in the form of hives, a less common occurrence than whiplash syndrome and one without a direct relation to bodily injury. Most studies of psychosomatic illnesses focus on chronic urticaria lasting longer than 6 weeks rather than on the acute form of hives, as in this case. Early descriptions refer to a “psychosomatic formula” in which “the bodily process emerged, or recurred, on meeting an emotionally upsetting event” (Mitchell, Curran, & Myers, 1947). The incidence of PTSD was found to be higher among patients with chronic idiopathic urticaria than it was in a matched control group of allergy patients, suggesting that traumatic memories or emotions could be manifested through the skin (Chung, Symons, Gilliam, & Kaminski, 2010). Although no studies of urticaria and EFT have been performed yet, EFT

seems particularly well suited for addressing such physical manifestations of stress.

PTSD

The third case is similar to the second case in that both involved women who had histories of previous MVA. In one study, a history of prior MVA was a predictor of acute stress severity in survivors of car accidents, suggesting the possibility of identifying those who may benefit from early treatment (Harvey & Bryant, 1999). In a study of victims of violent crime, the incidence of PTSD was higher in women than men (38% vs. 14%), and a diagnosis of ASD led to an eventual diagnosis of PTSD in 83% of the victims (Brewin, Andrews, Rose, & Kirk, 1999). The woman in the third case had no history of treatment for stress following either of her two car accidents. Perhaps her PTSD could have been prevented if, as in the second case, early intervention with EP had been offered. Randomized prospective controlled trials of EP versus CBT versus EMDR will be required to answer such questions, but there are indications that all of these techniques have some level of effectiveness.

This case dramatically showed the ability of EFT to resolve long-term symptoms of PTSD and whiplash syndrome following a car accident in a single session. The potential for EFT and other EP approaches such as Thought Field Therapy and negative affect erasing method to accelerate the healing of PTSD merits further study in comparison to other more well-established techniques. Thus far, few randomized controlled trials of EFT have been performed, with the initial one being a favorable comparison of single-session EFT to diaphragmatic breathing for phobias of small animals (Wells, Polglase, Andrews, Carrington, & Baker, 2003). A more recent single-session study showed better results for EFT than Progressive Muscle Relaxation for test anxiety (Sezgin & Özcan, 2009). As Feinstein (2008a) indicated, the accumulated body of evidence for the efficacy of EP is rapidly expanding, and the treatment of PTSD after MVA is fertile ground for further research.

Conclusion

These three case reports of rapid relief of stress-related symptoms after MVA with EFT highlight the potential for the use of EP approaches in the settings of immediate psychological trauma,

ASD, and PTSD. The possibility for significantly shortening the length of treatment should be intriguing to health policy analysts who are charged with allocating limited healthcare resources. Similar to the logic expressed by Sugarman and Burk (1998) that physicians have an ethical obligation to learn about alternative medicine to safeguard the best interests of their patients, a case can logically be made that psychologists and other mental health professionals have an ethical obligation to learn about EP. Whether or not they choose to incorporate such corporal methods into their practice is up to them, but preliminary research indicates that their patients are likely to benefit from the use of EP.

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