

## EFT rules in the NHS – Liz Kirsopp Feb 09

1) We NHS EFTers need lots of mutual support and supervision from other EFTers – it takes a lot of bottle to keep risking making a fool of yourself professionally and it is easy to get discouraged at the first patient refusal or raised medical eyebrow.

2) Don't *necessarily* ask NHS colleagues/managers permission to do EFT – if the work is within your existing professional competences. Start doing it when you feel confident in using it for yourself and use it first on simple issues that are recommended in the literature (eg phobia and simple trauma as per Andrade & Feinstein) Explain loudly what you are doing to all colleagues and referrers before they get alarmed by report-backs of an EFT failure! Your confidence will be what they remember. Remember that your manager needs reassurance about this too. It can help a lot to have names and ranks of EFTers elsewhere who are working in a similar field to yourself. Fee free to quote my name!

3) Take time before introducing EFT to a patient – build the relationship first. This might take many sessions or half an hour.

4) Tailor your introductory spiel towards the patients' views of the world in general and problems and treatment in particular. They may be amenable to explanations about meridians and acupuncture or they may prefer to think of it simply as a way of involving the body in psychological treatments as body and mind are not really separate and work best together. You can illustrate this eg imagining a lemon – or Brad Pitt. Or remembering a walk and a talk with someone and whether that was better than the talk alone.

5) Offer an informed and confident choice. Better to save EFT for later, potentially, than railroad them into trying it when they are not willing. They probably won't come back and may give bad feedback about you or EFT to others.

All the evidence suggests, when taken on a large enough scale, that no one therapy, not even an energy therapy, is better than any other, even for specific problems. What matters is the quality of the relationship and that the therapist and client share beliefs about what works. (See Scott Miller at al's abundant evidence on <http://www.talkingcure.com>) EFT is just as dangerous as any other idea when it is the only one you have.

6) Explain that in EFT the T is for techniques, not therapy, so most of what you do, apart from the actual tapping is taken from existing therapies.

7) It may be best to offer EFT as a self help adjunct first. Talk them through it, give materials and practise a few times with them and suggest how they might use it but let them come round to it to using it in therapy at a later stage if they want.

8) Use as much of possible of the patients' own words. Check out any flights of ideas of your own that arise from theirs. Offer yours tentatively. People are often compliant in a medical setting and are way too polite to tell you when you are off on one.

9) Keep meticulous written records of the statements that you use in EFT. Use scores or other forms of calibration. You can share these with the patient and they may be useful for homework. As well as the predations of age and seeing 25 people a week, I tend to find that EFT adversely affects my memory and I need the detailed written record to remind me where we were at and to take the patient back to really find out whether it has helped or not and if it did what worked.

10) In spite of all of the above, patients may still attribute their progress to things other than the EFT. Maybe that doesn't matter as long as it works. I think it does matter a bit because they are not likely to use EFT again for themselves if they don't experience it as working. And, on the odd occasions when I have had adverse feedback from a GP or other professional it has usually been in such cases – the EFT worked fine; the patient didn't notice! So these cases can put our credibility back too. I can only work harder to ensure full informed consent and collaboration and to calibrate progress meticulously.