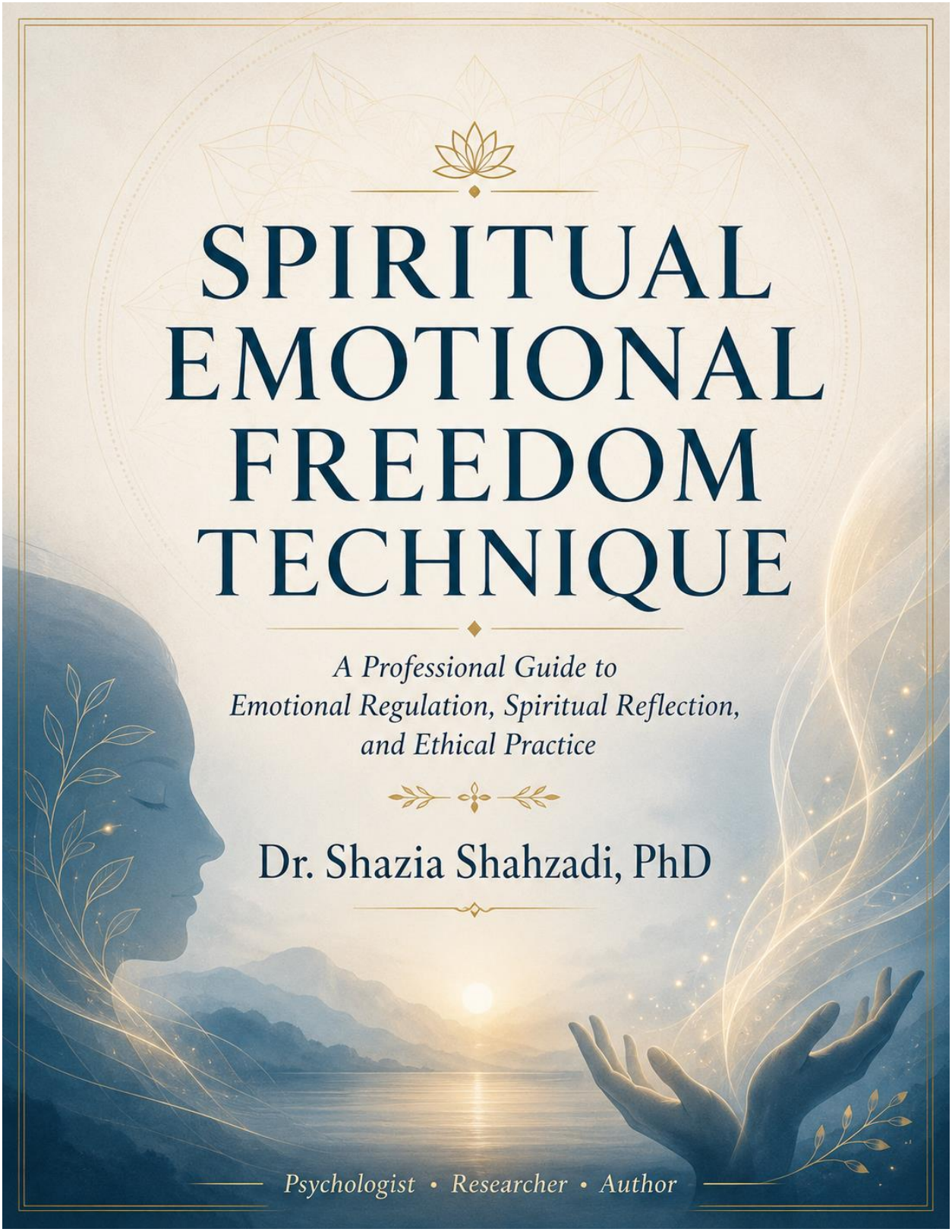
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Title:

Spiritual Emotional Freedom Technique

Subtitle:

A Professional Guide to Emotional Regulation, Spiritual Integration, Tapping Practice, and Ethical Application

Author:

Dr. Shazia Shahzadi, Ph.D. , Postdoctoral fellowship (Malaysia)

Planned illustrations

1. Principal EFT and SEFT tapping points
2. The three stages of SEFT
3. The emotion–thought–body–spirit relationship
4. The Subjective Units of Distress Scale
5. The window of emotional tolerance
6. Structure of a professional SEFT session
7. Trauma-safety decision pathway
8. Self-practice record sheet

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SPIRITUAL EMOTIONAL FREEDOM TECHNIQUE (SEFT)

A Professional Guide to Emotional Regulation, Spiritual Integration, Tapping Practice, and Ethical Application

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First Edition

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Educational purpose

This book provides an educational and professional introduction to Spiritual Emotional Freedom Technique. It is not intended to diagnose a mental or physical health condition, prescribe medical treatment, or replace care from a qualified physician, psychologist, psychiatrist, psychotherapist, or other regulated healthcare professional.

SEFT may be used as:

- A structured emotional-regulation exercise;
- A spiritually sensitive self-help practice;
- An adjunct to counselling or psychotherapy when used within professional competence;
- A method for increasing awareness of emotional and bodily responses.

It should not be presented as a guaranteed cure for psychological disorders, neurological conditions, chronic illness, infection, cancer, cardiovascular disease, or any other medical condition.

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People experiencing suicidal thoughts, psychosis, mania, severe dissociation, uncontrolled substance use, domestic violence, acute trauma reactions, or a medical emergency require appropriate professional assessment. Tapping should not delay emergency care, medication, psychological treatment, or medical investigation.

Spiritual responsibility

Spiritual language must be selected with the person's informed agreement. A practitioner should never impose personal beliefs, interpret illness as a consequence of weak faith, or suggest that unsuccessful treatment reflects insufficient prayer, sincerity, or spiritual worth.

Testimonials

I had heard of Spiritual Emotional Freedom Technique (SEFT) created by Ahmad Zainuddin, but could not find an English translation. While originally developed in Indonesia for people of the Islamic faith, its principles can be adapted to all religious traditions, including those who are agnostics. Now Dr. Shazia Shahzadi has written a book on the subject which is accurate, comprehensive, and useful for both practitioners and general readers. The book successfully combines spiritual awareness with practical emotional-healing techniques in a thoughtful and responsible manner. It is a pleasure to read, and I'm sure it will bring great healing, awareness and understanding to people all over the world.

John Freedom, CEHP
Chair, Research Committee
Association for Comprehensive Energy Psychology (ACEP), USA
Author, Heal Yourself with Emotional Freedom Technique
Executive Director, Finding Recovery and Empowerment from Abuse (FREA)

"Spiritual Emotional Freedom Technique is a thoughtful and professionally responsible contribution to the growing field of mind–body and spiritually integrated psychological practice. Dr. Shazia Shahzadi brings together emotional regulation, tapping practice, spiritual meaning, ethical safeguards, and research awareness in a clear and accessible manner.

A particular strength of this book is its balanced position. SEFT presented neither as a miraculous cure nor as a replacement for medical or psychological treatment, but as a complementary practice that deserves careful application and further scientific investigation. This book will be valuable for psychologists, counsellors, educators, researchers, healthcare professionals, and readers interested in culturally and spiritually sensitive approaches to emotional well-being."

Professor. Dr. Elsadig Musa Ahmed
Professor, Multimedia University, Malaysia

"Dr. Shazia Shahzadi has produced a practical, compassionate, and intellectually balanced guide to Spiritual Emotional Freedom Technique. The book is distinguished by its clear structure, culturally responsive language, and strong emphasis on informed consent, professional boundaries, ethical responsibility, and respect for individual beliefs. By integrating psychological understanding with spiritual reflection, the author offers a framework that is both humane and professionally cautious. This work can make a meaningful contribution to teaching, professional training, personal reflection, and future research concerning emotionally and spiritually sensitive practices."

Professor. Dr. Juhary Ali, SDK
Dean, City Graduate School, City University, Malaysia

Note from the Author

This book nurtured from a simple but important question: **How can emotional healing honor both scientific responsibility and spiritual meaning?**

Throughout my professional journey as a psychologist, researcher, educator, therapist, and rehabilitation practitioner, I have observed that emotional suffering rarely exists in isolation. It influences the body, relationships, decision-making, professional functioning, self-worth, and a person's relationship with faith and meaning. At the same time, people do not always need complicated language to begin understanding their inner experiences. Sometimes, they need a safe structure through which they can pause, acknowledge what they feel, regulate emotional intensity, and decide what responsible action should follow.

Spiritual Emotional Freedom Technique has been written to provide such a structure. It presents SEFT not as a miraculous cure or replacement for professional treatment, but as a developing complementary practice that may support emotional awareness, self-regulation, spiritual reflection, and personal responsibility.

In writing this book, I have attempted to maintain a careful balance between openness and scientific caution. The reader will therefore find practical exercises, tapping sequences, spiritually adaptable statements, professional forms, ethical guidance, trauma-informed precautions, and a critical review of the available evidence. Equal attention has been given to what SEFT may offer and what it cannot responsibly claim.

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My sincere hope is that this book will help readers approach their emotions without shame, use spirituality without denying reality, and seek healing without surrendering critical judgment. Emotional freedom does not mean living without grief, fear, anger, uncertainty, or pain. It means developing the ability to experience these emotions without allowing them to control every decision.

May this work encourage greater compassion, ethical practice, meaningful research, and a deeper understanding of the connection between emotional health, human dignity, responsible action, and spiritual integrity.

Dr. Shazia Shahzadi, PhD
Psychologist, Researcher, Author, and Academic
Postdoctoral Research Fellow
PhD Supervisor and External Examiner

Preface

Human distress is rarely experienced in only one part of life. A painful event may appear as a thought, but it may also be felt as tightness in the chest, restlessness, disturbed sleep, anger, shame, fear, helplessness, or withdrawal from other people. For many individuals, distress also raises spiritual questions: *Why did this happen? How should I respond? Where can I find meaning, patience, or hope?*

Spiritual Emotional Freedom Technique, commonly abbreviated as SEFT, attempts to work at the meeting point of emotional awareness, bodily stimulation, focused language, acceptance, prayer, and personal meaning. Its practical structure has been influenced by Emotional Freedom Techniques, a tapping-based approach that combines attention to distressing material with gentle stimulation of selected points on the face, hand, and upper body.

The defining feature of SEFT is not tapping alone. It is the way tapping is placed within a spiritual attitude. The individual is encouraged to acknowledge the difficulty honestly, remain attentive to its emotional or physical expression, and adopt an attitude of sincerity, acceptance, prayer, and surrender. In the original Indonesian literature, these qualities are frequently expressed through the concepts of *khusyuk*, *ikhlas*, and *pasrah*: focused spiritual presence, sincere acceptance, and surrender to God.

These ideas require careful interpretation. Acceptance does not mean approving injustice, remaining in danger, abandoning treatment, or becoming passive. Surrender does not mean giving up responsibility. Within ethical practice, acceptance means recognizing the present experience without adding unnecessary internal struggle. Spiritual surrender means acknowledging the limits of personal control while continuing to make responsible choices.

This book has four purposes.

First, it explains the historical and conceptual relationship between EFT and SEFT. Second, it teaches the basic procedure in language suitable for students, counsellors, healthcare workers, educators, researchers, and informed members of the public. Third, it examines available research without exaggerating its certainty. Finally, it establishes boundaries for safe, respectful, and professionally accountable use.

The reader will encounter both practical exercises and critical discussion. Some people report immediate reductions in subjective distress after tapping, while others experience gradual, limited, or no change. A responsible book must make room for all these possibilities. A technique should be evaluated not by impressive promises but by the quality of its theory, research, ethical delivery, and effect on the individual receiving it.

SEFT is therefore presented here neither as a miracle method nor as an idea to be dismissed without examination. It is approached as a developing, spiritually integrated practice whose possible value

should be studied with intellectual openness, clinical caution, and respect for the person's beliefs and autonomy.

Contents

Part I: Understanding the Approach

Chapter 1. What Spiritual Emotional Freedom Technique Is
Origins, terminology, defining features, and distinctions from other therapies

Chapter 2. Emotions, the Body, and Spiritual Meaning
Emotional activation, bodily responses, attention, acceptance, prayer, and self-compassion

Chapter 3. From EFT to SEFT
The development of tapping approaches and the spiritual adaptation introduced by Ahmad Faiz Zainuddin

Part II: Learning the Method

Chapter 4. Preparing for a SEFT Session
Consent, emotional safety, issue selection, distress ratings, and realistic goals

Chapter 5. The Three Core Stages
Set-up, tune-in, and tapping

Chapter 6. The Tapping Points
Locations, sequence, pressure, pace, and physical adaptations

Chapter 7. Developing Effective Statements
Specific language, emotional accuracy, acceptance, prayer, and culturally appropriate wording

Part III: Applications

Chapter 8. Stress, Anxiety, Anger, and Emotional Overload

Chapter 9. Grief, Rejection, Shame, and Relationship Pain

Chapter 10. Physical Symptoms and Chronic Illness
Supportive use without confusing emotional care with medical treatment

Chapter 11. Trauma-Informed SEFT
Stabilization, titration, dissociation, boundaries, and referral

Part IV: Evidence and Professional Practice

Chapter 12. What Research Suggests—and What It Does Not Establish

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Chapter 13. Ethics, Competence, and Spiritual Sensitivity

Chapter 14. Self-Practice and Guided Practice

Worksheets

References

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Chapter 1

What Spiritual Emotional Freedom Technique Is

Spiritual Emotional Freedom Technique is a structured mind–body practice in which a person attends to an emotional or physical concern while gently tapping selected points on the hand, face, head, and upper body. This physical activity is combined with verbal acknowledgement of the problem and a spiritually meaningful attitude such as prayer, sincerity, acceptance, trust, or surrender.

The approach is generally described through three stages:

1. **Set-up:** identifying the problem and forming an acceptance- or prayer-based statement;
2. **Tune-in:** bringing careful attention to the associated emotion, memory, thought, or bodily sensation;
3. **Tapping:** gently stimulating a sequence of selected points while maintaining focused awareness.

These stages are consistently reported in SEFT literature, although the precise statements, number of tapping points, session length, and spiritual language vary across practitioners and studies.

1.1 The Meaning of "Spiritual"

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In SEFT, spirituality is not simply an additional affirmation placed at the end of a tapping exercise. It influences the person's attitude throughout the process.

A spiritually grounded session may include:

- honest recognition of suffering;
- willingness to experience an emotion without denial;
- prayer for guidance or relief;
- acceptance of what has already occurred;
- trust in God or a transcendent source of meaning;
- recognition that personal effort and spiritual surrender can coexist;
- compassion towards oneself and other people.

For a Muslim participant, an appropriate internal attitude might involve *dua*, *tawakkul*, *sabr*, *ikhlas*, or acceptance of human limitations before Allah. A Christian participant might use language concerning God's presence, grace, forgiveness, or trust. A person from another faith tradition may use concepts consistent with that tradition. A nonreligious individual may prefer values-based language such as dignity, compassion, connection, meaning, or acceptance.

The practitioner's responsibility is not to select the person's spiritual worldview. The practitioner's role is to understand how the person already makes meaning of suffering and to determine whether spiritual content would be supportive.

1.2 The Meaning of "Emotional"

The word *emotional* refers to more than visible expressions such as crying or anger. Emotions involve subjective experience, physiological activation, interpretation, motivation, and patterns of behavior. A person may describe fear as a thought, "Something terrible will happen" but may simultaneously experience rapid breathing, muscular tension, an urge to escape, and difficulty concentrating.

A SEFT session therefore does not work only with an emotion's name. It attempts to identify the complete experience:

"When I remember the meeting, I feel humiliation in my chest, and I believe that everyone considers me incompetent."

This description is more useful than the general statement:

"I feel bad."

Specificity enables the individual to remain connected to one manageable part of the experience. It also allows change to be observed more accurately.

1.3 The Meaning of "Freedom"

The term *freedom* should not be understood as permanent elimination of all painful emotion. Fear, sadness, anger, guilt, and grief can be normal and protective responses. Emotional freedom is better understood as a reduction in the extent to which an emotional reaction automatically controls attention, behavior, relationships, or self-perception.

A person may still remember a painful event but become able to think about it without the same degree of bodily alarm. Another person may continue to feel sadness while gaining enough stability to sleep, communicate, pray, work, or make decisions. In this sense, freedom means greater psychological flexibility rather than emotional numbness.

1.4 The Meaning of "Technique"

A technique is an organized method, not a complete explanation of human suffering. SEFT cannot replace a comprehensive assessment of biological, psychological, relational, social, cultural, and spiritual factors.

For example, persistent anxiety may be connected with:

- traumatic experiences;

- thyroid or cardiac problems;
- medication effects;
- sleep deprivation;
- family conflict;
- financial insecurity;
- workplace harassment;
- substance use;
- a recognized anxiety disorder.

Tapping may help a person regulate distress in the moment, but responsible practice still asks what is producing or maintaining that distress. A technique becomes unsafe when it is used to avoid necessary diagnosis, social intervention, psychotherapy, medication, safeguarding, or legal protection.

1.5 The Relationship Between EFT and SEFT

Emotional Freedom Techniques developed from earlier tapping approaches and became widely associated with Gary Craig during the 1990s. Modern descriptions generally characterize EFT as a combination of focused attention, exposure to emotionally relevant material, cognitive or verbal processing, self-acceptance, and stimulation of selected acupressure points.

A basic EFT round commonly includes:

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- Selecting a specific problem;
- Rating its subjective intensity;
- Forming a set-up statement;
- Tapping the side-of-hand point;
- Tapping points on the head, face;
- Tapping points on collarbone, and underarm;
- Using a short reminder phrase;
- Reassessing the emotional intensity.

EFT International currently lists nine principal locations in its introductory sequence: side of hand, top of head, eyebrow, side of eye, under eye, under nose, chin, collarbone, and underarm.

SEFT retained much of this practical framework but gave spiritual processes a more explicit and central role. Ahmad Faiz Zainuddin's book *Spiritual Emotional Freedom Technique for Healing, Success, Happiness and Greatness* is catalogued by the National Library of Indonesia, with editions associated with the late 2000s.

Descriptions of SEFT commonly emphasize:

- Focused prayer;
- Sincere acknowledgement of the problem;
- Acceptance of the present condition;
- Surrender of the outcome to God;

- Continued attention to the distress during tapping;
- A broader set of tapping points in some protocols.

The difference is therefore not merely the addition of the word *spiritual*. SEFT modifies the language, intention, emotional posture, and meaning assigned to the process.

1.6 SEFT Is Not Emotionally Focused Therapy

A frequent source of confusion is that the abbreviation EFT is also used for **Emotionally Focused Therapy**, a psychotherapy associated particularly with couple and attachment work.

Emotional Freedom Techniques and Emotionally Focused Therapy are not variations of the same treatment. They differ in their history, theory, procedures, training, and clinical application. This book uses:

- **EFT** for Emotional Freedom Techniques or tapping;
- **SEFT** for Spiritual Emotional Freedom Technique;
- the full expression **Emotionally Focused Therapy** whenever referring to the attachment-based psychotherapy.

Clear terminology is especially important in research papers, clinical records, training program, and informed-consent documents.

1.7 A Balanced Professional Definition

For the purposes of this book, SEFT is defined as:

A spiritually integrated emotional-regulation practice that combines focused awareness of a specific concern, acceptance- or prayer-based verbalization, and gentle tapping on selected body points, with the aim of reducing subjective distress and supporting more adaptive psychological and spiritual responding.

This definition intentionally avoids claiming that tapping corrects a scientifically established disturbance in a bodily "energy system." Meridian-based explanations remain part of the historical and practitioner literature, but the exact mechanisms responsible for observed changes are unsettled.

Possible explanations under discussion include exposure, attentional shifting, expectancy, breathing changes, therapeutic alliance, self-acceptance, cognitive reappraisal, somatic stimulation, autonomic regulation, and memory reconsolidation. Recent theoretical papers propose multi-component mechanisms, but these models remain under investigation rather than conclusively demonstrated.

That distinction is essential. A technique may produce useful experiences before researchers fully understand its mechanisms. At the same time, uncertainty about mechanism requires practitioners to avoid presenting hypotheses as established biological facts.

Chapter 2

Emotions, the Body, and Spiritual Meaning

An emotion is not confined to the mind. Fear may appear as a prediction of danger, but it can also be experienced as rapid breathing, tightness in the chest, trembling, muscular tension, nausea, restlessness, or an urge to escape. Anger may involve thoughts of injustice, heat in the face, pressure in the head, a raised voice, or an impulse to confront another person. Grief may be felt through heaviness, exhaustion, disrupted sleep, loss of appetite, or a sense of emptiness.

These reactions demonstrate that emotions are coordinated experiences involving thoughts, bodily sensations, attention, memories, motivation, behavior, and social context. Human beings do not merely think about an emotional event; they respond to it through the whole organism.

Spiritual Emotional Freedom Technique works within this interconnected experience. The individual identifies a specific emotional concern, observes how it is represented in the body, attends to the thoughts or memories connected with it, and introduces tapping alongside acceptance- or prayer-based language.

The purpose is not to force the emotion to disappear. The immediate aim is to create enough internal stability for the person to observe the experience more clearly and respond with greater flexibility.

2.1 Understanding Emotional Experience

Emotions help human beings recognize and respond to important situations. Fear alerts a person to possible threat. Anger may signal violation, unfairness, obstruction, or the need to protect a boundary. Sadness often follows loss or disappointment and can encourage withdrawal, reflection, or support-seeking. Guilt may arise when behavior conflicts with personal values, while shame involves a more global negative judgment of the self.

Emotions therefore have functions. The problem is not simply that an emotion exists. Difficulty develops when an emotional response becomes:

- excessively intense;
- persistent after the immediate danger has passed;
- disconnected from the present situation;
- repeatedly triggered by reminders of an earlier experience;
- expressed in harmful or impulsive behavior;
- suppressed until it appears through bodily distress;
- interpreted as evidence of personal weakness;
- used as the sole basis for important decisions.

Emotion regulation refers to the processes through which individuals influence the emotions they experience, when those emotions arise, and how they are expressed. Regulation does not necessarily mean reducing every emotion. It may involve understanding an emotion, tolerating it,

modifying its intensity, changing its expression, or choosing behavior that remains consistent with personal values despite emotional discomfort.

A person may therefore regulate anger without denying that an injustice occurred. A grieving individual may regulate overwhelming distress without trying to erase love or attachment. Someone experiencing anxiety may learn to remain present while still taking reasonable precautions.

SEFT should be understood as one possible method of supporting this regulatory process. It does not determine whether an emotion is rational or irrational, nor does it resolve every external problem associated with distress.

2.2 The Body as Part of Emotional Awareness

The brain continuously receives information from the internal condition of the body. This includes signals associated with breathing, heartbeat, muscle tension, temperature, digestion, pain, fatigue, and other physiological processes.

The sensing, interpretation, and integration of internal bodily signals is commonly described as **interoception**. It contributes to emotional experience because bodily changes help shape how a person recognizes and interprets what is happening internally.

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For example, a person preparing to speak before an audience may notice:

“My heart is beating quickly, my hands feel cold, and there is pressure in my stomach.”

These sensations might be interpreted as:

“I am going to fail.”

Another person could experience similar physical activation but interpret it as:

“My body is preparing me to perform.”

The bodily response alone does not completely determine the emotional meaning. Memory, beliefs, expectations, culture, past experience, and the immediate environment influence how sensations are understood.

This is relevant to SEFT because the individual is often asked to identify where an emotion is felt in the body. Instead of working only with the general phrase “I am anxious,” the practitioner may ask:

“Where do you notice the anxiety most clearly?”

The individual may identify tension in the jaw, pressure behind the eyes, heaviness in the chest, shaking in the hands, or discomfort in the stomach.

This focused observation can make a vague emotional state more specific and measurable. Research on mind–body interventions suggests that the capacity to notice and interpret bodily signals is closely connected with emotion regulation, although the direction and strength of this relationship differ across people and methods of measurement.

Observing Without Diagnosing

A bodily sensation noticed during SEFT should not automatically be interpreted as emotional in origin. Chest pressure, shortness of breath, dizziness, persistent pain, weakness, or changes in consciousness may require medical assessment.

A practitioner should avoid statements such as:

"Your pain is caused entirely by blocked emotion."

Such a conclusion exceeds what can be established through tapping. Physical symptoms may have medical, neurological, psychological, behavioral, or mixed causes.

A safer statement is:

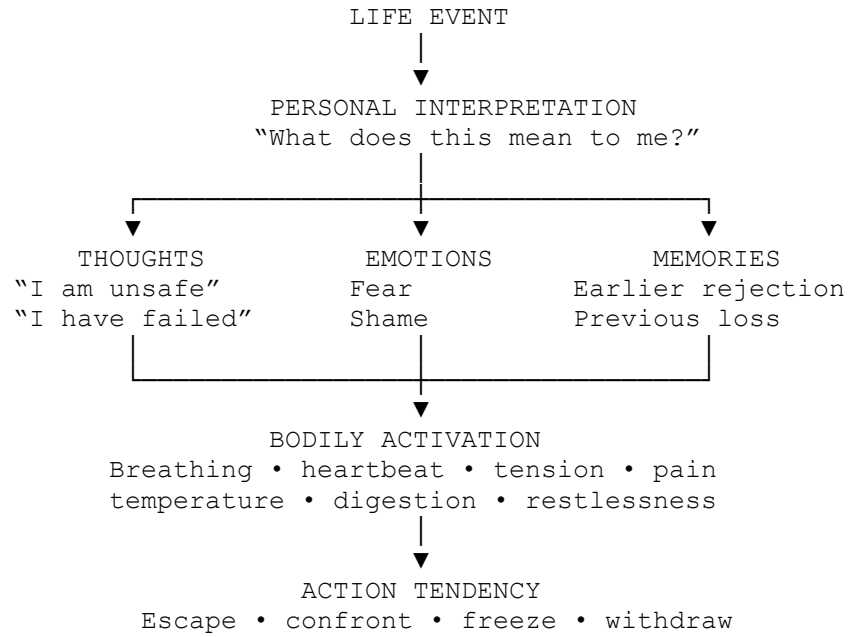
"We can observe whether emotional stress influences the intensity of the sensation, while you continue to follow appropriate medical advice."

This language allows exploration without replacing medical investigation.

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Figure 1

The Emotion–Thought–Body–Spirit Relationship



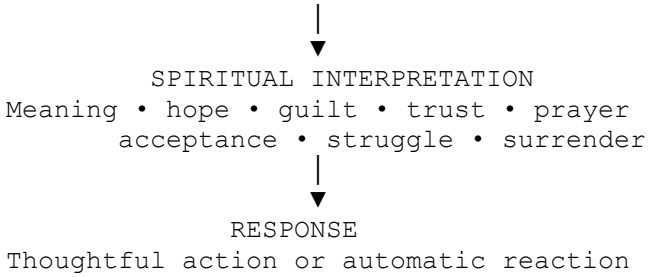


Figure note. The elements in this framework influence one another rather than operating in a fixed one-way sequence. A bodily sensation can influence thought, spiritual interpretation can change behavior, and social action can alter emotional experience.

2.3 Attention and the Emotional Response

Attention influences which parts of an experience become most prominent. When people feel threatened, attention often narrows towards signs of danger. A person who fears rejection may closely monitor another person's facial expression, tone of voice, response time, or choice of words. Ambiguous behavior may then be interpreted as evidence of disapproval.

In a SEFT exercise, attention is deliberately directed towards one manageable element of the problem. This may be:

- a specific memory;
- a sentence spoken by another person;
- a mental image;
- a feared future event;
- an emotion;
- a bodily sensation;
- a belief about oneself;
- a spiritual concern.

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This focused attention resembles an important feature of EFT, in which tapping is performed while the person remains aware of an uncomfortable thought, emotion, or sensation. EFT International similarly describes the method as tapping while giving focused attention to difficult internal experiences.

However, attention must be carefully regulated. Focusing too little may result in a mechanical exercise that does not connect with the relevant experience. Focusing too intensely may overwhelm the person, particularly when the concern involves trauma, abuse, bereavement, severe humiliation, or frightening medical events.

Professional practice therefore uses **graduated attention**. The individual approaches distress in small, tolerable amounts rather than being forced to relive the whole experience.

A practitioner might say:

"You do not need to enter the most painful part of the memory. For now, notice only the discomfort that arises when you think about discussing it."

This approach protects the individual's sense of control.

2.4 Naming the Experience

People frequently use general words such as *stress*, *tension*, *upset*, or *disturbance*. These descriptions are valid starting points, but they may contain several distinct experiences.

For example, "stress about my job" could include:

- fear of dismissal;
- anger towards a supervisor;
- humiliation after criticism;
- guilt about reduced performance;
- exhaustion from excessive workload;
- resentment about unfair treatment;
- financial fear concerning the family;
- hopelessness about finding another position.

Each element may require different language and a different tapping focus.

SEFT becomes more precise when the individual identifies:

1. what happened;
2. what emotion is present;
3. where the emotion is experienced in the body;
4. what meaning has been attached to the event;
5. what outcome is feared;
6. what spiritual concern has emerged.

A more specific statement might be:

"When I remember my supervisor criticizing me in front of the department, I feel humiliation in my face and chest. I fear that my colleagues now consider me incompetent."

This formulation provides a clearer focus than:

"I am stressed about work."

Specificity also helps determine whether distress has changed. The general problem of employment may remain unresolved even when the emotional intensity associated with one humiliating incident decreases.

2.5 The Difference Between Acceptance and Approval

Acceptance is central to many SEFT set-up statements, but it is easily misunderstood.

Acceptance does not mean that a painful event was acceptable. It does not require a person to approve abuse, discrimination, betrayal, exploitation, neglect, or injustice. It does not mean abandoning legal rights, remaining silent, or reconciling with someone who continues to cause harm.

Psychological acceptance means recognizing the present internal experience without wasting additional energy denying that it exists.

A person may say:

"I do not approve of what happened, but I accept that this anger is present in me today."

This creates a distinction between the external event and the current emotional reality.

Avoidance may provide short-term relief, but repeated attempts to escape thoughts, emotions, memories, or sensations can sometimes contribute to the maintenance of distress. Acceptance-based work aims to change the person's relationship with difficult experiences rather than demanding their immediate elimination.

In SEFT, acceptance is therefore not passivity. It is a stable position from which responsible action becomes more possible.

2.6 Spiritual Meaning and Emotional Regulation

Many people interpret major events through a spiritual or religious framework. Illness, bereavement, family conflict, disability, infertility, financial loss, professional failure, and traumatic experiences may raise questions about justice, purpose, responsibility, divine care, punishment, forgiveness, patience, and hope.

Spirituality may support emotional regulation by providing:

- a sense of meaning;
- hope during uncertainty;
- a framework for patience;
- connection with a faith community;
- rituals that create continuity and structure;
- language for forgiveness or gratitude;
- a relationship with God or a transcendent reality;
- a belief that suffering does not define the whole person.

Research suggests that religion and spirituality can contribute positively to mental health through meaning, supportive relationships, positive beliefs, and constructive religious coping. However, spiritual beliefs can also intensify distress when they involve fear of divine abandonment, excessive guilt, punishment beliefs, conflict with a religious community, or the belief that emotional suffering proves weak faith.

This distinction is particularly important in SEFT. Spiritual language should not automatically be assumed to be comforting.

A person may find strength in saying:

"I ask Allah for guidance and place what I cannot control in His care."

Another person may become more distressed by spiritual language because the central problem involves religious guilt or a painful experience with a religious authority.

The practitioner must therefore assess whether spiritual integration represents:

- a source of support;
- a source of conflict;
- both support and conflict;
- or an area the person does not wish to include.

2.7 Positive and Negative Religious Coping

Positive religious coping may include seeking spiritual support, finding meaning, engaging in compassionate prayer, trusting God while taking responsible action, and drawing strength from a faith community.

Negative religious coping may include believing that one has been abandoned or punished by God, viewing every difficulty as evidence of moral failure, feeling rejected by a religious community, or experiencing persistent spiritual conflict.

Research has repeatedly distinguished between these forms of coping. Positive religious coping is generally associated with more adaptive adjustment, whereas spiritual struggle and negative religious coping are more often associated with psychological distress. These relationships are not uniform, and the effect of spirituality depends on personal meaning, context, culture, and the nature of the stressor.

A spiritually sensitive practitioner does not respond to negative religious coping by debating theology or offering a religious lecture. The practitioner listens carefully and, when appropriate, collaborates with a trusted and psychologically informed religious scholar, chaplain, or spiritual adviser chosen by the client.

2.8 Prayer Within SEFT

Prayer can serve several psychological and spiritual functions. It may help the person express pain, organize attention, acknowledge dependence, seek courage, reflect on values, experience connection, or place uncontrollable concerns within a larger framework of meaning.

Nevertheless, prayer should not be described as a scientifically guaranteed cure. Research on prayer and health is complex, and findings depend on the type of prayer, research design, population, outcome, and meaning assigned by the individual. Reviews have found potential benefits in some contexts while also emphasizing methodological limitations and the need for cautious interpretation.

In SEFT, prayer is most ethically used as an expression of the participant's own beliefs rather than as a formula imposed by the practitioner.

A person may prefer wording such as:

"O Allah, I acknowledge this fear. Please guide me towards patience, wisdom, and the right action."

Another may say:

"God, help me face this grief without losing hope."

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A nonreligious participant may use:

"I acknowledge this pain and choose to respond with patience and self-respect."

The emotional function may be similar, but the language must remain personally authentic.

2.9 Sincerity, Acceptance, and Surrender

SEFT literature frequently describes three spiritual attitudes: focused presence, sincerity, and surrender. These ideas can be translated into professional psychological language without removing their spiritual significance.

Focused Presence

Focused presence means giving full attention to the exercise rather than repeating words mechanically. The individual notices the issue, the bodily response, the emotional intensity, and the meaning carried by the words.

Focused presence is not forced concentration. Thoughts may wander. The person simply returns attention to the selected issue without self-criticism.

Sincerity

Sincerity means acknowledging the experience honestly. A person is not required to claim complete acceptance, forgiveness, or peace when those states are not genuinely present.

For example, the statement:

"I completely forgive everyone involved"

may be inappropriate when the individual remains deeply angry or unsafe.

A more appropriate statement might be:

"I am not ready to forgive, but I am willing to reduce the harm this anger is causing me."

This wording respects the person's actual emotional position.

Surrender

Surrender means recognizing the limits of personal control while continuing to take responsible action. It is not resignation.

A person can surrender the final outcome of a medical treatment while attending appointments, taking prescribed medication, asking questions, and seeking another opinion when necessary. A person can place trust in God while setting boundaries, reporting abuse, applying for employment, or leaving a dangerous environment.

Healthy surrender reduces the demand to control every outcome. Unhealthy resignation removes personal agency.

2.10 Self-Compassion and Spiritual Responsibility

People often respond to emotional difficulty with harsh self-judgment:

"I should be stronger."

"A faithful person would not feel this anxious."

"I have no right to be upset."

"My inability to forgive makes me a bad person."

Such statements add shame to the original distress.

Self-compassion involves responding to personal suffering with understanding rather than contempt. It does not excuse harmful behavior or remove accountability. Instead, it creates a psychological position from which behavior can be examined more honestly.

Systematic reviews suggest that self-compassion is associated with emotion-regulation processes and psychological well-being, although the evidence varies across populations and study designs.

Within SEFT, self-compassion may be expressed through language such as:

"Even though I regret what happened, I acknowledge that I am a human being capable of learning and taking responsibility."

Or:

"Although this experience has affected me deeply, I choose not to treat myself as an enemy."

Where faith-based language is desired:

"Allah knows my struggle. I ask for guidance, mercy, and the strength to correct what is within my responsibility."

The purpose is not to replace accountability with comfort. It is to prevent shame from making constructive change impossible.

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2.11 A Practical Framework for SEFT

Before tapping, an individual can organize the experience through four domains.

1. Emotional Domain

What emotion is present?

Examples include fear, sadness, anger, shame, guilt, helplessness, loneliness, disappointment, jealousy, or grief.

2. Cognitive Domain

What thought or interpretation accompanies the emotion?

Examples include:

"I am not safe."

"Nobody respects me."

"I will never recover."

"This should not have happened."

"I have disappointed God."

3. Bodily Domain

Where is the experience felt?

Examples include the chest, throat, head, shoulders, stomach, jaw, back, hands, or legs.

The person may describe the sensation using qualities such as pressure, heat, coldness, heaviness, tightness, trembling, numbness, or emptiness.

4. Spiritual Domain

What spiritual meaning has been attached to the experience?

Examples include:

"I feel abandoned."

"I cannot understand why this was allowed to happen."

"I need patience but feel unable to find it."

"I want to trust God, but I am frightened."

"I feel guilty when I pray."

Not every SEFT session requires content in all four domains. The framework is intended to clarify the experience, not to force complexity.

2.12 Illustrative Example

A university lecturer becomes anxious before presenting research at an international conference.

The concern may initially be described as:

"I am afraid of presenting."

Closer exploration may reveal:

Emotion: Fear and shame.

Thought: "If I make a mistake, everyone will discover that I am not competent."

Body: Tightness in the throat and trembling in the hands.

Memory: Being publicly criticized by a senior teacher many years earlier.

Spiritual meaning: "I have prayed for success, but I still feel afraid. Perhaps my faith is not strong enough."

A professionally framed SEFT statement could be:

"Even though I feel this tightness in my throat when I imagine standing before the audience, and part of me fears being humiliated again, I acknowledge this fear with honesty. I ask Allah for steadiness, wisdom, and the courage to perform according to my preparation."

This statement:

- identifies the specific trigger;
- includes the bodily response;
- recognizes the connection with an earlier experience;
- avoids claiming that fear proves weak faith;
- includes prayer without promising a particular outcome;
- supports responsible action based on preparation.

The person may then rate the distress from 0 to 10, complete a tapping round, and observe what changes.

The fear may decrease. It may shift from the throat to the stomach. A new memory may emerge. The person may realize that the main concern is not the audience but one particular senior colleague. Each response provides information for the next stage of the process.

2.13 Chapter Summary

Emotions are coordinated experiences involving cognition, bodily activation, memory, attention, behavior, relationships, and meaning. SEFT works with these dimensions by combining focused awareness, verbal acknowledgement, tapping, and spiritually congruent language.

The body should be observed without assuming that every symptom is psychological. Acceptance should not be confused with approval, passivity, or tolerance of abuse. Spirituality may strengthen hope and meaning, but it may also become a source of guilt or conflict. Prayer, surrender, and religious language must therefore be used according to the person's own beliefs and preferences.

The central principle is not that distress must immediately disappear. The principle is that a person can learn to face an experience with greater awareness, reduced internal struggle, and a more deliberate response.

Reflection Exercise

Choose one current concern that is moderately uncomfortable but not overwhelming.

Complete the following sentences:

The situation is:

The main emotion is:

The intensity from 0 to 10 is:

I feel it in my body as:

The thought connected with it is:

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The spiritual meaning, concern, or source of support is:

What I need at this moment is:

This exercise is for observation only. A full tapping procedure will be introduced in Chapters 4–6.

Chapter 3

From EFT to SEFT

Spiritual Emotional Freedom Technique did not emerge as an entirely separate practice. It developed through the adaptation of earlier tapping approaches, particularly Emotional Freedom Techniques. Understanding this history is important because the techniques share several procedures but differ in their language, philosophy, spiritual emphasis, and explanation of change.

The development can be viewed through three broad stages:

1. **Thought Field Therapy**, associated with Roger Callahan;
2. **Emotional Freedom Techniques**, developed and systematized by Gary Craig;
3. **Spiritual Emotional Freedom Technique**, developed by Ahmad Faiz Zainuddin.

This history is often described in practitioner literature as a simple line of discovery. In reality, the development was less straightforward. Ideas from exposure-based psychology, cognitive methods, subjective distress measurement, acupuncture traditions, applied kinesiology, self-acceptance statements, prayer, and spiritual coping were brought together over time.

Some historical claims are well documented. Others depend mainly on accounts provided by the founders or their followers. A professional discussion must therefore distinguish between documented development, theoretical interpretation, and personal testimony.

3.1 Thought Field Therapy

Thought Field Therapy, commonly called TFT, was developed by American clinical psychologist Roger Callahan. The approach became known for combining focused attention to a psychological problem with tapping on selected points of the body.

In TFT, the practitioner traditionally selected different tapping sequences, known as algorithms, for different emotional problems. A sequence for fear might differ from one intended for anger, trauma, guilt, or another concern. Some forms of TFT also incorporated muscle testing and diagnostic procedures intended to determine the appropriate order of points.

The term *thought field* reflected Callahan's proposal that thinking about a distressing issue activated an informational or energetic field connected with that problem. Tapping particular points was believed to correct disturbances within that field.

These explanations were influential within the emerging field of energy psychology, but they were not accepted as established principles within mainstream psychology, neuroscience, or physiology. The existence of a distinct "thought field" in the sense proposed by TFT has not been demonstrated through conventional scientific methods.

This does not mean that every experience reported after TFT must be dismissed. It means that an observed change in distress does not, by itself, prove the theoretical explanation offered for that change.

A person may feel calmer after a tapping procedure because of several interacting processes, including:

- focused exposure to the problem;
- interruption of repetitive thinking;
- changes in breathing;
- sensory stimulation;
- increased expectation of relief;
- therapeutic attention;
- verbal reframing;
- repeated measurement of distress;
- a sense of control and participation.

The contribution of each element remains a matter of investigation.

3.2 Gary Craig and the Simplification of Tapping

Gary Craig studied Callahan's approach and later developed Emotional Freedom Techniques. Rather than using a different diagnostic algorithm for every problem, Craig introduced a more standardized sequence in which the same principal points could be tapped for many different concerns.

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EFT International describes its core method as a system developed by Craig from the earlier discoveries of Callahan. The standardized sequence made the procedure easier to teach, remember, repeat, and use as a self-help exercise.

This simplification was historically significant. TFT generally placed greater emphasis on selecting the correct algorithm, while EFT proposed that tapping through a common sequence could reduce the need for specialized energetic diagnosis.

Craig's early procedure became known as the **Basic Recipe**. It included:

- identifying a specific problem;
- rating emotional intensity;
- creating a set-up statement;
- tapping the side of the hand;
- tapping a sequence of facial and upper-body points;
- using a short reminder phrase;
- completing additional procedures in the original extended version;
- reassessing emotional intensity.

The original Basic Recipe included the nine-gamut procedure, eye movements, humming, counting, and a repeated tapping sequence. Many modern EFT protocols use a shorter form, although the extended procedure remains part of the method's historical development.

Figure 2

Historical Development of the Principal Tapping Approaches

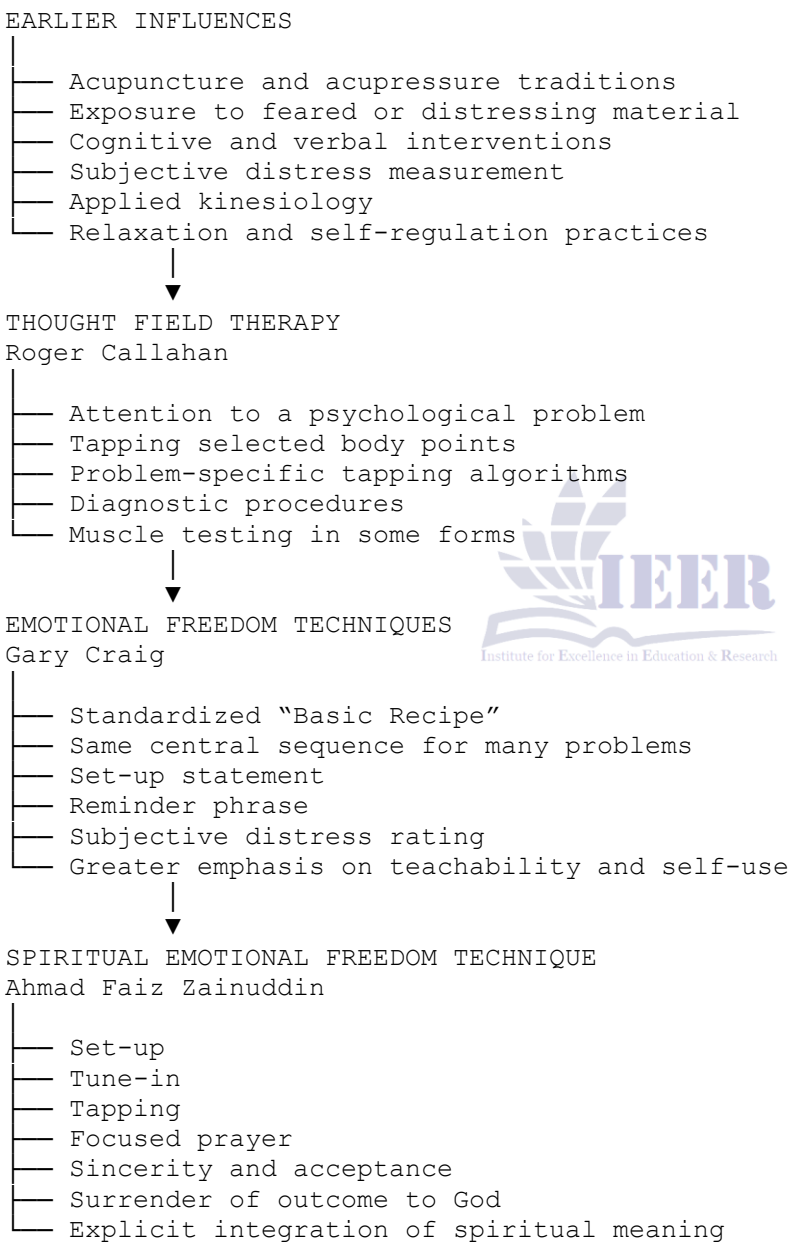


Figure note. This diagram represents conceptual development, not proof that every theoretical assumption of an earlier approach was retained or scientifically validated.

3.3 What EFT Retained from TFT

EFT retained several central features of Thought Field Therapy.

Attention to a Specific Problem

Both approaches ask the person to bring a distressing issue into awareness. This may involve remembering an event, imagining a feared situation, noticing physical discomfort, or naming an emotion.

Tapping During Emotional Activation

The individual taps selected points while the problem is mentally or emotionally active. The procedure therefore combines exposure to distressing material with a competing physical activity.

Repeated Assessment

Both approaches pay attention to changes in distress during the session. EFT commonly uses a 0–10 Subjective Units of Distress rating, although subjective ratings originated in behavioral therapy rather than tapping methods.

Acu-Point-Based Interpretation

Both TFT and EFT traditionally interpret the tapping locations through ideas derived from acupuncture meridians or the body's energy system.

Brief, Structured Intervention

Both methods are designed around relatively concise procedures that can be repeated when distress remains present or when another aspect of the problem emerges.

3.4 What EFT Changed

EFT altered the earlier procedure in several important ways.

A Common Tapping Sequence

Craig proposed that a standard sequence could be used across many emotional concerns. This reduced reliance on condition-specific algorithms.

Greater Accessibility

The simplified structure allowed the method to be taught through manuals, demonstrations, workshops, and later online materials. EFT resources describe the approach as suitable for self-

use in lower-risk situations, while also recommending professional support for complex or severe problems.

The Set-Up Statement

The set-up statement generally combines acknowledgement of the problem with a form of self-acceptance. A familiar structure is:

"Even though I have this problem, I deeply and completely accept myself."

The wording can be adapted because some people find complete self-acceptance unrealistic, culturally uncomfortable, or emotionally inaccessible. A more credible statement may be:

"Even though I feel this fear, I am willing to acknowledge what I am experiencing."

Emphasis on Specific Events

Developed EFT practice increasingly emphasized specific memories and particular emotional aspects rather than broad labels.

For example:

"My fear of public speaking"

may be narrowed to:

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"The moment my teacher laughed at my mistake during a class presentation."

This specificity helps the individual work with a manageable emotional target rather than an entire life problem.

The Reminder Phrase

While tapping through the sequence, a brief phrase is repeated to maintain attention on the selected concern:

"This fear in my chest."

"That humiliating comment."

"The sadness when she left."

The phrase is not intended to create distress unnecessarily. Its purpose is to keep the emotional target clear enough for the individual to notice whether its intensity or meaning changes.

3.5 The Early EFT Explanation

Gary Craig's early explanatory statement proposed that negative emotions resulted from disturbances in the body's energy system. This idea became widely repeated in EFT training and practitioner materials.

From a scientific perspective, this statement should be treated as a historical theory rather than a proven fact.

There is no generally accepted clinical test that can directly identify an EFT "energy disruption," determine its precise location, or demonstrate that it has been corrected by tapping. The concept of acupuncture meridians also does not correspond neatly with structures recognized in conventional anatomy.

This theoretical uncertainty has led to two contrasting positions.

One position argues that stimulation of particular acu-points provides an active therapeutic component. A 2018 systematic review and meta-analysis of comparative studies reported moderately stronger outcomes for acu-point tapping than control procedures, although the number and quality of available component studies were limited.

The opposing position argues that benefits may arise primarily from established psychological processes such as exposure, attention, expectancy, breathing, cognitive reframing, distraction, and therapeutic support. Critics have also questioned the methodological quality of parts of the energy-psychology evidence base.

The current evidence does not justify presenting either a meridian mechanism or a single conventional psychological mechanism as definitively established. A 2025 systematic review of EFT for anxiety described the intervention as promising but concluded that heterogeneity and methodological limitations prevented firm conclusions.

A responsible author can therefore describe what is done during EFT without overstating why it works.

3.6 The Development of SEFT

Ahmad Faiz Zainuddin adapted tapping into a more explicitly spiritual framework and named the method **Spiritual Emotional Freedom Technique**.

The National Library of Indonesia catalogues Zainuddin's book under the title *Spiritual Emotional Freedom Technique [SEFT] for Healing + Success, Happiness + Greatness*. The catalogue records an illustrated edition published in Jakarta by Afzan Publishing in 2009. Secondary publications cite editions dated 2006, 2012, or 2018, suggesting that the work has circulated in

more than one edition or bibliographic form. For accuracy, this book does not assign one unquestionable publication year to the entire development of SEFT.

SEFT retained the practical structure of tapping but placed spiritual attitudes at the center of the intervention. Published descriptions usually organize the method around:

1. **The set-up**
2. **The tune-in**
3. **The tapping sequence**

The spiritual component is especially visible in the set-up and tune-in stages. The person acknowledges the problem, prays, accepts the present experience, and surrenders the final outcome to God while continuing to take appropriate personal action.

In many Indonesian studies, the process is described through qualities such as:

- confidence or trust;
- focused spiritual presence;
- sincerity;
- acceptance;
- surrender;
- gratitude.

SEFT literature sometimes refers to the combination of energy psychology and spiritual practice as an **amplifying effect**. This is a concept within the SEFT model, not a scientifically established law.

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3.7 The Three Principal Stages of SEFT

The Set-Up

During the set-up, the individual identifies the problem and recites a spiritually oriented statement, often while tapping the side-of-hand point or applying gentle pressure to a sensitive upper-chest location described in SEFT literature as the *sore spot*.

A traditional statement may follow this pattern:

“O Allah, although I feel this fear, I sincerely accept my present condition, and I surrender my healing and the outcome to You.”

The statement contains three movements:

1. Acknowledgement of the problem;
2. Acceptance of the current reality;
3. Surrender of the outcome.

For professional application, the wording should not imply that the individual must accept abuse, injustice, or preventable harm. The person may accept that an emotional reaction currently exists while continuing to reject the harmful behavior that caused it.

The Tune-In

During tune-in, attention is directed towards the relevant memory, emotion, thought, image, or physical sensation.

For an emotional concern, the person may recall one particular part of an event. For physical discomfort, the person may observe the location and quality of the sensation without assuming that the problem is entirely psychological.

A short spiritual phrase may be repeated:

"O Allah, I acknowledge this fear and place it before You."

"I accept that this pain is present at this moment."

"Guide me towards the right response."

Tune-in should not become forced reliving. The person retains the right to pause, reduce the intensity, change the target, or stop the session.

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Tapping

Tapping is conducted while the person remains gently connected with the selected issue. Some SEFT protocols describe tapping eighteen points, while others use shorter sequences containing approximately nine principal points. This variation across publications means that there is no single sequence consistently reported in every research study labelled SEFT.

This inconsistency is important for research. Studies cannot be compared accurately unless authors report:

- The points used;
- The number of rounds;
- The wording of prayers;
- Session duration;
- Practitioner training;
- Individual or group delivery;
- Home practice;
- Modifications to the original protocol.

Table 1: Principal Similarities and Differences Between TFT, EFT, and SEFT

Feature	Thought Field Therapy	Emotional Freedom Techniques	Spiritual Emotional Freedom Technique
Principal developer	Roger Callahan	Gary Craig	Ahmad Faiz Zainuddin
Attention to distress	Yes	Yes	Yes
Tapping body points	Yes	Yes	Yes
Standard sequence	Usually problem-specific algorithms	Common basic sequence	Varies; often based on EFT with additional points
Muscle testing	Used in traditional forms	Generally not required	Generally not central
Set-up statement	Not identical to modern EFT	Problem acknowledgement plus self-acceptance	Problem acknowledgement plus acceptance, prayer, and surrender
Subjective distress rating	May be used	Commonly used	Used in some protocols but inconsistently reported
Explicit prayer	Not essential	Optional	Central in traditional SEFT
Spiritual surrender	Not central	May be included by individual practitioners	Defining feature
Self-help use	Limited by diagnostic complexity	Common for lower-risk concerns	Commonly taught, but complex cases require professional care
Traditional explanation	Disturbance in a thought field or energy system	Disturbance in the body's energy system	Energy psychology strengthened by spiritual practice
Scientific status of mechanism	Unestablished	Unestablished	Unestablished

3.8 SEFT Is More Than a Translated Set-Up Statement

It would be inaccurate to describe SEFT as standard EFT with the word *Allah* inserted into the set-up phrase.

The spiritual adaptation changes several dimensions of the practice.

The Source of Healing

Traditional SEFT language places the ultimate source of healing with God rather than with the tapping procedure or practitioner.

This can protect against practitioner grandiosity. A practitioner should not present themselves as possessing exceptional spiritual power or claim personal responsibility for divine healing.

At the same time, attributing the outcome to God must not be used to discourage medical or psychological treatment. Spiritual trust and professional care can operate together.

The Attitude Towards Control

EFT often emphasizes reduction of emotional intensity. SEFT adds a deliberate willingness to surrender the final outcome. The person participates actively but does not demand complete control over the result.

The Meaning of Acceptance

SEFT places greater emphasis on sincere acceptance. This can help reduce conflict with the existence of an emotion, illness, loss, or uncertainty.

However, acceptance must be interpreted carefully. It refers to acknowledging present reality, not declaring every circumstance good or morally acceptable.

The Role of Prayer

Prayer is not merely a relaxation phrase. For a religious participant, it represents a genuine relationship with God. It may express dependence, hope, repentance, gratitude, patience, or a request for guidance.

The practitioner must therefore avoid using sacred language mechanically or manipulating it to obtain compliance.

The Moral and Relational Context

Spiritual concerns may include guilt, forgiveness, responsibility, injustice, repentance, family obligations, and moral injury. These issues cannot always be resolved through distress reduction alone.

A person may feel calmer after tapping but still need to:

- Apologize;
- Repair harm;
- Establish a boundary;
- Seek protection;
- Obtain legal advice;
- Make restitution;

- Consult a religious scholar;
- Engage in psychotherapy;
- Accept that reconciliation is unsafe or impossible.

Emotional relief does not automatically determine the correct moral action.

3.9 Is SEFT an Islamic Therapy?

SEFT developed in Indonesia and much of its published literature uses Islamic prayer language. References to Allah, sincerity, surrender, gratitude, and spiritually focused prayer are common in the method's traditional presentation.

It can therefore be described as strongly influenced by an Islamic spiritual context.

However, two cautions are necessary.

First, SEFT should not be presented as an established religious obligation, a form of worship prescribed in scripture, or a replacement for recognized Islamic spiritual practices. Tapping is a contemporary therapeutic or self-regulation procedure, not a religious requirement.

Second, applying the method with people from different beliefs requires genuine adaptation rather than superficial replacement of religious terms.

A Christian participant may prefer prayer centered on grace, God's presence, hope, or forgiveness. A Hindu, Buddhist, Sikh, Jewish, or other religious participant may draw upon concepts from their own tradition. A person who does not hold a religious belief may prefer language of meaning, values, compassion, acceptance, or connection.

The practitioner should ask:

"Would you like spiritual or religious language to be included?"

"Which words feel natural and respectful to you?"

"Are there any expressions you do not want used?"

The participant's answer, not the practitioner's belief, should guide the session.

3.10 Cultural Adaptation and Cultural Imposition

Cultural adaptation occurs when a method is adjusted to fit a person's language, values, family structure, beliefs, and understanding of distress.

Cultural imposition occurs when the practitioner assumes that all members of a religious or national group think in the same way.

For example, two Muslim participants may have very different preferences. One may find direct prayer deeply comforting. Another may prefer neutral clinical language because religious guilt is part of the presenting problem. Both responses deserve respect.

Similarly, an individual may accept prayer but reject statements such as:

"This illness was sent because you needed a spiritual lesson."

Such interpretations should never be imposed. They may increase guilt, shame, or confusion and cannot be established by the practitioner.

3.11 Historical Claims That Require Caution

Several claims commonly appear in tapping literature but should be approached carefully.

"Tapping Is Thousands of Years Old"

Acupuncture traditions are ancient, but EFT and SEFT are modern systems. The fact that tapping locations are described in relation to acupuncture does not make the complete EFT or SEFT procedure thousands of years old.

"EFT Was Scientifically Proven from the Beginning"

Early popularity developed largely through demonstrations, workshops, case accounts, manuals, and practitioner reports. Controlled research expanded later. Early claims sometimes went beyond the strength of the evidence available at the time.

"SEFT Has Proven That Prayer Multiplies the Effect of Tapping"

The concept of an amplifying effect belongs to SEFT theory. To establish scientifically that prayer multiplies the independent effect of tapping, studies would need to compare clearly defined conditions such as:

- Tapping alone;
- Prayer alone;
- Combined tapping and prayer;
- An active psychological comparison;
- An appropriate control condition.

Such research would also need adequate samples, standardized protocols, blinded outcome assessment where possible, and replication by independent investigators.

"One Tapping Sequence Treats Every Condition"

A common sequence may be applied to different concerns, but this does not mean that all disorders share the same causes or require identical treatment.

A panic attack, traumatic grief, obsessive-compulsive disorder, psychosis, domestic abuse, chronic pain, and ordinary performance anxiety require different forms of assessment and care.

"Immediate Relief Proves Permanent Healing"

A reduction from 8 to 3 on a subjective distress scale is meaningful for the individual, but it does not prove long-term recovery. Follow-up assessment is required to determine whether change is maintained and whether daily functioning has improved.

3.12 What Can Be Retained Without Accepting Every Historical Theory?

A practitioner does not have to accept all traditional energy explanations in order to examine the practical structure of SEFT.

The following elements can be studied independently:

- Selecting a specific emotional target;
- Rating subjective distress;
- Naming thoughts and bodily sensations;
- Approaching difficult material gradually;
- Combining emotional attention with repetitive sensory stimulation;
- Using language of acceptance;
- Integrating personally meaningful prayer;
- Reassessing change;
- Supporting deliberate rather than automatic action.

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This position allows scientific inquiry and spiritual respect to coexist. The spiritual meaning of prayer can be honored without claiming that its biological mechanism has been conclusively demonstrated. Similarly, a reduction in distress can be documented without assuming that an invisible energy blockage has been measured and removed.

3.13 A Contemporary Professional Position

SEFT is best understood as a developing, spiritually integrated tapping practice.

Its historical roots lie in TFT and EFT. Its distinctive contribution is the explicit integration of prayer, sincerity, acceptance, gratitude, and surrender. Its potential usefulness should be evaluated through careful clinical observation and increasingly rigorous research.

A responsible contemporary position includes the following principles:

1. **The person comes before the technique.**
   The method must be adapted to the individual rather than forcing the individual to fit the method.
2. **Spirituality requires consent.**
   Prayer and religious language should never be imposed.

3. **Mechanisms should not be overstated.**
   Meridian and energy explanations remain theoretical.
4. **Immediate subjective change is not the same as clinical recovery.**
5. **SEFT may complement appropriate care but should not replace necessary treatment.**
6. **Complex trauma and severe mental illness require appropriately trained professionals.**
7. **Research must report the actual protocol used.**
8. **Respect for faith must be accompanied by respect for evidence.**

3.14 Chapter Summary

Thought Field Therapy introduced a structured combination of attention to psychological distress and tapping selected body points. Gary Craig simplified this approach into Emotional Freedom Techniques by replacing many problem-specific algorithms with a more standardized procedure.

Ahmad Faiz Zainuddin subsequently developed Spiritual Emotional Freedom Technique, retaining the set-up, focused attention, and tapping process while giving prayer, sincerity, acceptance, gratitude, and surrender a central role.

The historical development does not establish the truth of every theory attached to these practices. Concepts such as thought fields, energy disruptions, meridian correction, and spiritual amplification require more direct scientific testing.

SEFT can be discussed professionally without either idealizing or dismissing it. Its procedures, outcomes, cultural meaning, ethical risks, and spiritual dimensions can all be examined separately. This balanced position provides the foundation for learning the method safely.

Reflection Exercise

Locating Your Professional Position

Consider each statement and record your response.

1. I view SEFT primarily as:
☐ A spiritual practice
☐ A psychological self-regulation method
☐ A complementary therapeutic technique
☐ A combination of these
☐ I remain uncertain

2. My present understanding of its mechanism is:

3. The spiritual language that feels appropriate to me is:

---

4. Spiritual expressions I would not want imposed are:

---

5. Situations in which I would seek professional assistance rather than rely on self-tapping include:

---

6. The most important ethical principle for me is:

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Chapter 4

Preparing for a SEFT Session

The effectiveness and safety of a SEFT session depend partly on what happens before tapping begins. Preparation is not a formality. It determines whether the issue is suitable for self-practice, whether the person understands the method, whether spiritual language is welcome, and whether sufficient emotional stability is present to continue.

A poorly prepared session may become mechanical, confusing, or emotionally overwhelming. A well-prepared session establishes:

- Informed choice;
- Physical and emotional safety;
- Realistic expectations;
- A clear and manageable focus;
- An initial measure of distress;
- Permission to pause or stop;
- An appropriate plan for follow-up.

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Preparation is especially important when SEFT is used by counsellors, psychologists, healthcare professionals, educators, spiritual-care providers, or trained practitioners. The individual receiving the intervention should never feel pressured to disclose painful details, accept religious language, tolerate physical contact, or continue after asking to stop.

The basic principle is simple: **The person must remain more important than the procedure.**

4.1 Creating a Safe Therapeutic Environment

A SEFT session should begin in an environment that supports privacy, dignity, and personal control.

The physical setting should be reasonably quiet, comfortable, and free from avoidable interruption. The person should know where the exits are, where water is available, and whether anyone may enter the room. For online sessions, the practitioner should confirm that the person has sufficient privacy and a stable means of communication.

Emotional safety is equally important. The person should understand that:

- Participation is voluntary;

- There is no obligation to reveal every detail;
- Tapping may be stopped at any time;
- The intensity of the work can be reduced;
- Spiritual language can be changed or removed;
- The person will not be judged for emotional reactions;
- The technique does not guarantee a particular result.

SAMHSA describes trauma-informed practice through principles that include safety, trustworthiness, transparency, collaboration, empowerment, voice, choice, peer support, and attention to cultural and historical factors. These principles are highly relevant to SEFT, especially when the person has experienced trauma, coercion, abuse, displacement, discrimination, medical crisis, or loss of control.

Safety does not mean that no discomfort will arise. Emotional work often involves some discomfort. Safety means that the person remains informed, respected, supported, and able to influence the pace and direction of the session.

4.2 Practitioner Presence

Before teaching tapping, the practitioner should become emotionally present.

A practitioner who appears hurried, distracted, overly enthusiastic, or determined to demonstrate a dramatic result may make it harder for the person to speak honestly. The practitioner should listen without immediately converting every statement into a tapping phrase.

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Preparation includes noticing:

- The person's pace of speech;
- Breathing and bodily tension;
- Ability to remain oriented to the room;
- Degree of emotional activation;
- Willingness to participate;
- Expectations of the method;
- Spiritual comfort or conflict;
- Existing professional support.

The practitioner's tone should communicate steadiness rather than urgency.

Statements such as the following may help:

"We will work only with what feels manageable today."

"You remain in control of the pace."

"You do not need to tell me the full story."

"We can stop, change the wording, or move away from the issue at any time."

These statements are not merely reassuring. They restore choice, which is especially important for people whose distress involved coercion, helplessness, or violation of personal boundaries.

4.3 Informed Consent

Informed consent means more than obtaining a signature. It is an ongoing process through which the person receives understandable information and voluntarily agrees to participate.

Before a professionally guided SEFT session, the practitioner should explain:

1. What SEFT involves;
2. What will happen during the session;
3. The possible emotional and physical responses;
4. The limitations of the method;
5. Reasonable alternatives;
6. Confidentiality and its limits;
7. The practitioner's qualifications and scope of practice;
8. The person's right to decline, pause, or withdraw;
9. Whether the session will be recorded;
10. How spiritual language will be selected.

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EFT International's ethical guidance emphasizes client autonomy, informed consent, professional boundaries, safe practice, respect for medical care, and referral when symptoms are prolonged, concerning, or potentially life-threatening. Its code also advises practitioners not to challenge medical diagnoses unless they possess the relevant medical qualifications.

A Plain-Language Explanation

A practitioner may introduce SEFT as follows:

"SEFT combines focused attention to an emotional or bodily concern with gentle tapping on selected points. It may also include prayer or acceptance-based language when that is consistent with your beliefs. Some people notice reduced distress, some notice gradual change, and some notice little or no change. It is not a substitute for medical or psychological treatment. You may stop at any time."

This explanation is more ethical than saying:

"This method will remove your emotional blockage."

Or:

"Your problem will be cured when your energy is balanced."

The first description explains the procedure and acknowledges uncertainty. The second presents a theoretical claim as fact and creates an unrealistic expectation.

4.4 Consent for Spiritual Content

Consent to tapping does not automatically mean consent to prayer.

Before using religious or spiritual language, ask directly:

"Would you like spirituality or prayer included in this session?"

"Which words feel natural to you?"

"Is there any religious language you prefer not to use?"

Some individuals may want direct prayer. Others may prefer a quiet spiritual intention. Some may want entirely secular language. A person may also change their preference during the session.

A Muslim participant might choose:

"O Allah, help me face this fear with patience and wisdom."

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Another Muslim participant might prefer:

"Although this fear is present, I acknowledge it and choose to respond calmly."

Neither statement is more spiritually or psychologically legitimate merely because one uses explicit religious language.

The practitioner should never imply that:

- Prayer is required for tapping to work;
- A person's distress reflects weak faith;
- Failure to improve reflects inadequate sincerity;
- The practitioner knows the divine purpose of the illness;
- Forgiveness must occur immediately;
- Surrender requires tolerating injustice.

Spiritual integration should reduce coercion, not create another form of it.

4.5 Consent for Touch

In most circumstances, individuals should tap on their own bodies. Self-tapping protects personal boundaries and increases the person's sense of control.

A practitioner should not touch a client merely because certain points are difficult to locate. The points can be demonstrated on the practitioner's own face and upper body, shown on a diagram, or described verbally.

When direct touch is considered necessary in a professional setting, the practitioner must:

- Explain why touch is being proposed;
- Identify the exact location;
- Request explicit permission;
- Offer a no-touch alternative;
- Consider cultural, religious, gender, medical, and trauma-related factors;
- Stop immediately if the person appears uncomfortable;
- Follow the ethical rules of the practitioner's profession and jurisdiction.

Silence, nervous laughter, immobility, or failure to object should not be interpreted as meaningful consent.

Recommended Principle: Demonstrate on yourself; allow the participant to tap on themselves.

This is the clearest default for both individual and group sessions.

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4.6 Determining Whether SEFT Is Appropriate

SEFT may be suitable for lower-intensity concerns such as:

- Ordinary situational stress;
- Mild performance anxiety;
- Frustration;
- Manageable anger;
- Disappointment;
- Difficulty settling before sleep;
- Emotional discomfort connected with a specific event;
- Preparation for a challenging but safe conversation;
- Distress associated with a medically assessed condition.

Suitability depends not only on the topic but also on the person's current condition, history, support, and capacity to remain emotionally regulated.

A minor event for one person may activate severe trauma in another. Conversely, a person may discuss a major life event while remaining stable and well supported.

The practitioner should ask:

"How intense does this feel when you think about it now?"

"Do you feel able to remain present while discussing a small part of it?"

"What usually happens when this memory becomes strong?"

"What helps you regain stability?"

"Do you have professional or personal support available after the session?"

The purpose is not to diagnose beyond one's competence. It is to determine whether the planned exercise is likely to remain within a safe and manageable range.

4.7 Situations Requiring Greater Caution

Self-directed or minimally supervised SEFT is not appropriate for every concern.

Greater caution is needed when the person reports:

- Recent suicidal thoughts or self-harm;
- Thoughts of harming another person;
- Hallucinations or severe loss of contact with reality;
- Mania or extreme behavioral activation;
- Severe dissociation;
- Frequent blackouts or unexplained loss of awareness;
- Uncontrolled substance intoxication or withdrawal;
- Continuing domestic violence or abuse;
- An immediate safeguarding concern;
- Severe traumatic flashbacks;
- Unstable medical symptoms;
- Recent major bereavement with marked functional collapse;
- Inability to provide informed consent;
- Intense distress without adequate support.

These concerns do not necessarily mean that tapping can never be used. They mean that tapping should not be presented as the primary or sufficient response. Appropriate assessment, crisis intervention, safeguarding, medical care, psychiatric care, or trauma-focused treatment may be required.

NICE continues to list EFT for adult PTSD as a research question rather than a recommended first-line PTSD intervention. Its PTSD guideline recommends recognized trauma-focused psychological treatments and emphasizes attention to dissociation, emotional dysregulation, substance misuse, interpersonal difficulties, and other barriers to engagement.

A SEFT practitioner should therefore avoid claiming to provide trauma treatment unless appropriately qualified, trained, supervised, and legally authorized to do so.

4.8 Medical Symptoms

SEFT should not be used to determine whether a symptom is medically serious.

Urgent medical assessment may be necessary for symptoms such as:

- Chest pain or pressure;
- Severe breathing difficulty;
- Sudden weakness or numbness;
- Facial drooping;
- Sudden confusion;
- Seizure;
- Loss of consciousness;
- Severe allergic reaction;
- Uncontrolled bleeding;
- Severe or rapidly worsening pain;
- Suicidal overdose or poisoning.

Tapping may be used for emotional support while appropriate medical assistance is being obtained, but it must not delay emergency action.

For persistent non-emergency symptoms, the practitioner should ask whether the individual has consulted a qualified medical professional. EFT International's code specifically advises referral for symptoms that are prolonged, concerning, or potentially life-threatening.

4.9 Medication and Existing Treatment

A practitioner who is not medically qualified should not advise a person to stop, reduce, increase, or replace prescribed medication.

If distress decreases during tapping, this does not prove that medication is no longer required. Decisions about psychiatric, neurological, cardiovascular, diabetic, hormonal, pain-related, or other medication should be made with the prescribing clinician.

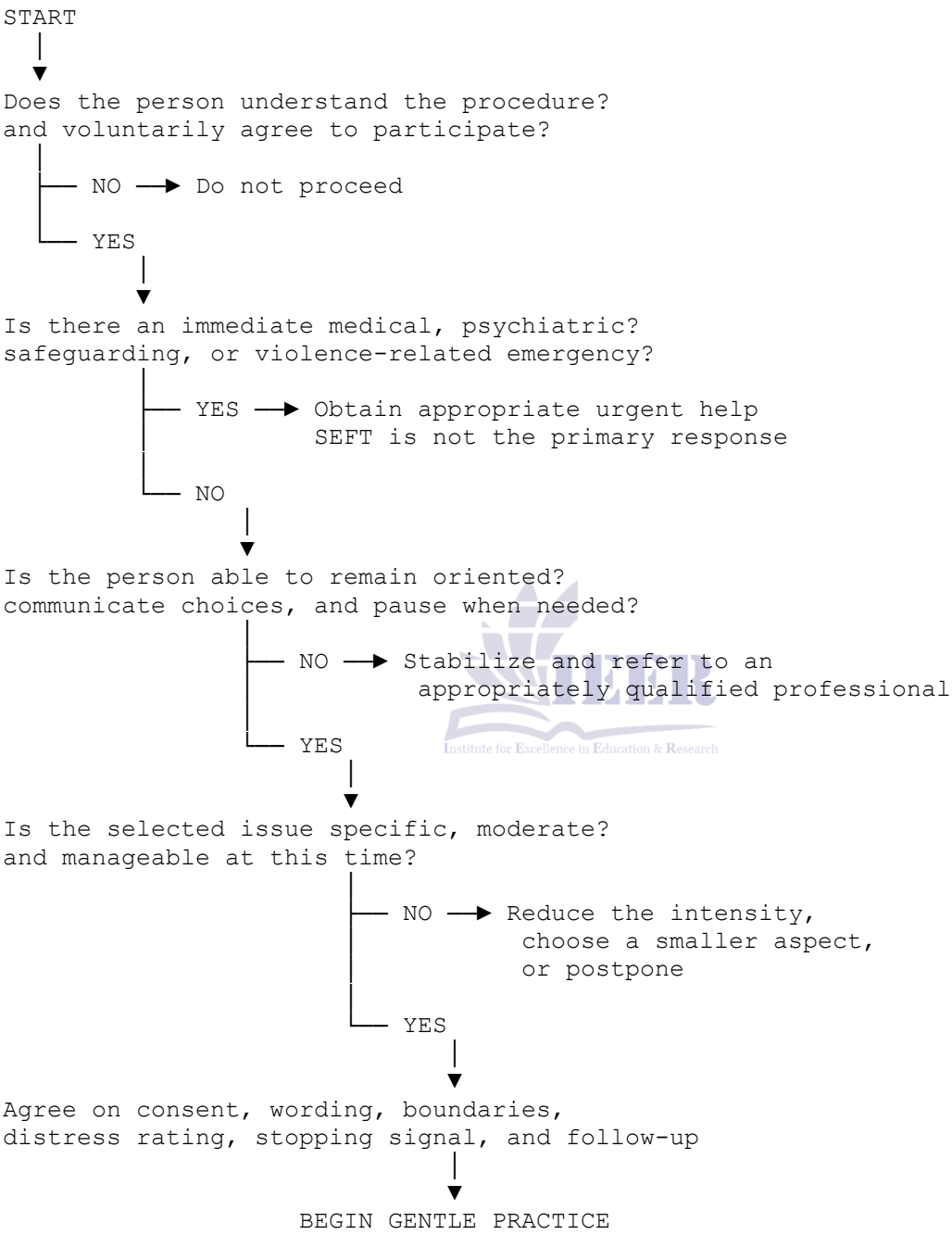
Similarly, SEFT should not interrupt an established psychological treatment plan without discussion with the treating professional.

A collaborative statement is:

"You may use this as a supplementary emotional-regulation exercise while continuing the treatment recommended by your qualified healthcare provider."

Figure 3

Initial SEFT Safety Decision Pathway



4.10 Selecting a Manageable Issue

A common mistake is to begin with a problem that is too broad.

Examples include:

“My entire childhood.”

“My marriage.”

“My depression.”

“All my anger.”

“My fear of failure.”

These concerns may contain dozens of events, beliefs, relationships, emotions, and bodily responses. Attempting to address the whole problem in one tapping round makes it difficult to focus attention or evaluate change.

A more useful target is a specific aspect:

“The moment my father shouted at me during dinner when I was twelve.”

“The tightness in my chest when my husband does not respond to my message.”

“The image of the examination hall.”

“The sentence my supervisor used during yesterday’s meeting.”

“My fear that the medical test will show a serious illness.”

The target should be specific enough to observe but not so intense that the person becomes overwhelmed.

The Camera Test

Ask:

“Could this event be described as a short scene that a camera might have recorded?”

A specific event usually has:

- A place;
- An approximate time;
- Particular people;

- A beginning;
- A central moment;
- An ending.

For example:

“My mother never supported me”

is a broad conclusion.

A camera-test event might be:

“The afternoon she remained silent when my relatives criticized my education.”

The broad conclusion may have developed through several events. Working with one representative scene often provides a clearer starting point.

4.11 Beginning with the Edge of the Problem

The person does not need to begin with the most painful part.

A gentler target may be:

“The discomfort I feel about considering this memory.”

“The fear that I will become overwhelmed.”

“The tension in my shoulders while sitting here.”

“The image of the closed door, without discussing what happened behind it.”

This approach is sometimes called working at the edge of the issue. It permits contact without requiring full emotional immersion.

EFT training materials refer to gentle methods such as “sneaking up” on a problem and working without requiring full disclosure. EFT International nevertheless cautions that those using such approaches should be trauma-informed and, for complex work, appropriately trauma-trained.

4.12 Establishing a Baseline

Before tapping, the individual should identify the current level of distress.

A commonly used method is the **Subjective Units of Distress Scale**, often abbreviated as SUDS. The person rates the intensity from 0 to 10:

Rating	General description
0	No noticeable distress
1–2	Very mild discomfort
3–4	Mild to moderate discomfort
5–6	Clear and significant distress
7–8	High distress
9	Very high distress
10	Most intense distress the person can imagine or tolerate

The numbers do not represent a laboratory measurement. They are subjective markers that help the person compare the experience before and after a round.

The practitioner might ask:

“When you think about that specific moment now, how strong is the discomfort from 0 to 10?”

The person’s first answer should normally be accepted. Repeatedly questioning the rating may suggest that the practitioner expects a particular number.

What Should Be Rated?

The target of the rating should remain clear.

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Instead of:

“How bad is your life problem?”

ask:

“How strong is the tightness in your throat when you remember that sentence?”

Or:

“How intense is the anger towards your colleague at this moment?”

Distress, emotional intensity, bodily discomfort, belief strength, and urge to act are different variables. They should not be mixed without clarification.

4.13 When the Person Cannot Choose a Number

Some people find numerical ratings unnatural or difficult. Alternatives include:

- no distress, mild, moderate, strong, or overwhelming;
- a hand gesture showing small, medium, or large;
- the estimated size of the sensation;
- the distance between two hands;

- a colour or image;
- a visual analogue line;
- descriptions such as “tight,” “slightly softer,” or “unchanged.”

The purpose is to observe change, not to force numerical precision.

4.14 Recording the Baseline

A brief record may include:

Selected issue:
The comment made during Monday’s meeting.

Primary emotion:
Humiliation.

Body location:
Heat in the face and tightness in the chest.

SUDS rating:
7 out of 10.

Main thought:
“Everyone thinks I am incompetent.”

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Spiritual concern:
“I prayed for dignity but felt abandoned.”

Desired direction:
To remember the event without losing emotional control and to decide how to respond professionally.

Selected Issue	Primary Emotion	Body Location	SUDS Rating	Main Thought	Spiritual Concern	Desired Direction
The comment made during Monday’s meeting.	Humiliation	Heat in the face and tightness in the chest	7/10	“Everyone thinks I am incompetent.”	“I prayed for dignity but felt abandoned.”	To remember the event without losing emotional control and decide how to respond professionally.

The desired direction should remain realistic. It may be reasonable to seek reduced distress and clearer decision-making. It is not realistic to guarantee that every painful memory will disappear in one session.

4.15 Establishing a Stopping Signal

Before beginning, the practitioner and participant should agree on a clear way to pause.

The signal may be:

- Raising a hand;
- Saying “stop”;
- Placing both feet firmly on the floor;
- Lowering the tapping hand;
- Using a predetermined word.

The practitioner should stop immediately when the signal is used by client.

The person does not need to justify the request. Asking, “Why do you want to stop?” before actually stopping undermines the agreement.

After pausing, the practitioner may ask:

“Would you like silence, water, grounding, a change of subject, or to end the session?”

The person should be offered concrete choices without pressure to resume.

4.16 Signs That the Session Should Slow Down

The practitioner should watch for signs of increasing dysregulation:

- Rapid or shallow breathing;
- Marked trembling;
- Confusion;
- Inability to follow conversation;
- Sudden emotional numbness;
- Staring or appearing absent;
- Loss of awareness of the room;
- Repeated statements of being unsafe;
- Overwhelming panic;
- Severe dizziness;
- Inability to speak;
- Uncontrolled agitation;
- Abrupt collapse in posture;
- Disclosure of immediate danger.

These signs do not always indicate the same process. Some may reflect panic, dissociation, a medical problem, exhaustion, medication effects, or another condition.

The correct response is not to tap faster or insist that the emotion is "coming out." The session should slow down, attention should return to present safety, and appropriate professional or medical help should be considered.

4.17 Basic Grounding Before Tapping

A brief grounding exercise can be completed before addressing the issue.

Orientation Exercise

Invite the person to:

1. Notice the room;
2. Identify the door and windows;
3. Feel both feet against the floor;
4. Notice the support of the chair;
5. Name three neutral objects;
6. Take a comfortable breath without forcing it;
7. Remind themselves of the current date and location.

A practitioner might say:

"You are here in this room. The event is not occurring at this moment. You can decide how close to the memory you wish to go."

Grounding should not be presented as proof that the person is completely safe. Someone living with ongoing violence may not be safe outside the session. In that situation, practical safeguarding and support planning are more important than asking the individual to calm themselves.

4.18 Choosing a Session Goal

The goal should describe a helpful direction rather than an absolute demand.

Appropriate goals include:

- Reducing distress enough to think clearly;
- Remaining present while discussing a small part of the issue;
- Decreasing bodily tension;
- Preparing for a difficult conversation;
- Separating a current event from an earlier memory;
- Identifying the next responsible action;
- Increasing emotional steadiness before a medical appointment;
- Reducing the urge to respond impulsively.

Unhelpful goals include:

- "I must feel nothing."
- "I will erase the memory."
- "I must forgive today."
- "This will cure my illness."
- "I will never feel anxious again."
- "God must give me the outcome I want."

SEFT is better used to support emotional flexibility than to demand emotional perfection.

4.19 Preparing the Initial Statement

Once the issue, emotion, bodily sensation, and spiritual preference have been identified, the person can prepare an initial set-up statement.

A useful structure is:

"Even though I experience _____ when I think about _____, I acknowledge what I am feeling, and I ask for _____."

Example:

"Even though I feel pressure in my chest when I remember my supervisor's criticism, I acknowledge this hurt without judging myself, and I ask Allah for steadiness and wisdom in deciding how to respond."

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A secular version might be:

"Even though I feel pressure in my chest when I remember that criticism, I acknowledge this hurt and am willing to respond with steadiness and self-respect."

The wording should be:

- Specific;
- Truthful;
- Personally acceptable;
- Emotionally tolerable;
- Free from exaggerated promises;
- Consistent with the individual's beliefs.

4.20 Preparing for Self-Practice

Before using SEFT alone, the person should ask:

1. Is this issue mild or moderate rather than overwhelming?
2. Can I remain aware of my surroundings?
3. Do I know how to stop and ground myself?

4. Is someone available if I become distressed?
5. Am I using SEFT alongside, not instead of, needed care?
6. Am I physically stable enough to continue?
7. Have I selected only one manageable aspect?
8. Am I willing to stop if the intensity increases?

Self-practice is best learned first with neutral or lower-intensity concerns. Beginning alone with severe trauma is not a test of courage or commitment.

Table 2: Pre-Session Preparation Checklist

Preparation area	Questions to confirm
Consent	Does the person understand the method and agree voluntarily?
Expectations	Have benefits, uncertainty, and limitations been explained?
Spiritual preference	Does the person want prayer or spiritual language included?
Touch	Will the person tap on themselves? Has any proposed touch been explicitly discussed?
Scope	Is the issue within the practitioner's qualifications and legal role?
Immediate risk	Is there a medical, psychiatric, violence-related, or safeguarding emergency?
Emotional stability	Can the person remain oriented, communicate choices, and stop when needed?
Target	Is one specific and manageable aspect selected?
Baseline	Has the present intensity been recorded?
Stopping signal	Is there a clear and respected way to pause?
Grounding	Does the person know how to return attention to the present?
Follow-up	Is appropriate support available after the session?

4.21 Professional Record-Keeping

When SEFT is delivered as part of professional care, records should be accurate, restrained, and consistent with legal and professional requirements.

A session note may include:

- Date and duration;
- informed consent;
- Presenting concern;
- Selected target;
- Initial and final distress ratings;
- Wording used;
- Tapping sequence or adaptation;
- Significant emotional or physical responses;
- Grounding or stabilization methods;
- Risk concerns;
- Referrals or recommendations;

- Plan for follow-up.

Records should distinguish what the participant reported from what the practitioner observed.

For example:

Participant reported: "The tightness reduced from 7 to 4."

This is preferable to:

Energy blockage cleared by 50%.

The first is a report that can be documented. The second is an unverified interpretation.

Confidentiality limits should be explained before sensitive disclosure, particularly where there are concerns involving child abuse, vulnerable adults, imminent danger, or legal reporting obligations.

4.22 Online SEFT Sessions

Remote sessions require additional preparation.

Confirm:

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- the participant's current location;
- a telephone number or alternative contact method;
- who else is nearby;
- whether privacy is adequate;
- what will happen if the connection fails;
- whether the participant is driving or operating equipment;
- access to local emergency support;
- whether the participant can remain in a safe location after the session.

The person should not participate while driving, crossing roads, bathing, cooking over an open flame, or performing another activity requiring full attention.

For higher-risk work, the practitioner should know the participant's location at the beginning of each session. This information should be collected and stored according to relevant privacy requirements.

4.23 Group Preparation

SEFT is frequently taught in workshops or groups, but a group setting does not remove the need for consent and safety.

Participants should be told:

- they do not need to disclose personal details publicly;
- they may choose a mild private issue;
- they may use general wording;
- they may stop without explanation;
- confidentiality cannot be guaranteed in the same way as individual therapy;
- the facilitator cannot provide individual trauma treatment to every group member;
- support options are available if distress emerges.

A facilitator should avoid public demonstrations involving severe trauma, sexual abuse, domestic violence, suicidal experiences, or deeply private religious conflict unless the setting, consent, qualifications, and follow-up support are exceptionally well established.

Group members should not be encouraged to interpret one another's symptoms, diagnose spiritual weakness, or provide unsolicited physical contact.

4.24 Chapter Summary

Preparation establishes the ethical and emotional foundation of SEFT. Before tapping begins, the participant should understand the procedure, its limits, and the right to stop. Consent must cover not only participation but also spiritual language, touch, privacy, recording, and the handling of sensitive information.

The selected issue should be specific and manageable. A baseline should be established using a distress rating or another personally meaningful measure. The person and practitioner should agree on a stopping signal, grounding procedure, and realistic session goal.

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SEFT should not replace emergency care, medical diagnosis, safeguarding, psychiatric treatment, or recognized trauma treatment. Complex presentations require practitioners with appropriate qualifications, supervision, and referral pathways.

The most important preparation question is not:

"Which point should we tap first?"

It is:

"Can this person engage in this exercise with sufficient safety, understanding, dignity, and choice?"

Pre-Session Worksheet

Date:

The issue I want to address is:

The specific event, image, thought, or sensation is:

The main emotion is:

I notice it in my body at:

Its present intensity is:
_____ /10

The main thought or belief is:

I would like spiritual language included:
☐ Yes ☐ No ☐ Unsure

The spiritual wording that feels appropriate is:

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The words I do not want used are:

My stopping signal will be:

What will help me become grounded is:

The support available after the session is:

A realistic goal for this session is:

Chapter 5

The Three Core Stages of SEFT

Spiritual Emotional Freedom Technique is commonly organized into three connected stages:

1. **The set-up**
2. **The tune-in**
3. **The tapping sequence**

The stages are simple enough to remember, but effective practice requires more than repeating a prepared script. The person must identify a meaningful target, use language that feels truthful, remain connected with the experience without becoming overwhelmed, and observe what changes during the process.

Published SEFT descriptions consistently identify set-up, tune-in, and tapping as the central stages. Traditional protocols combine tapping with prayer, sincerity, acceptance, and surrender, although the wording and number of tapping points vary across studies and practitioners.

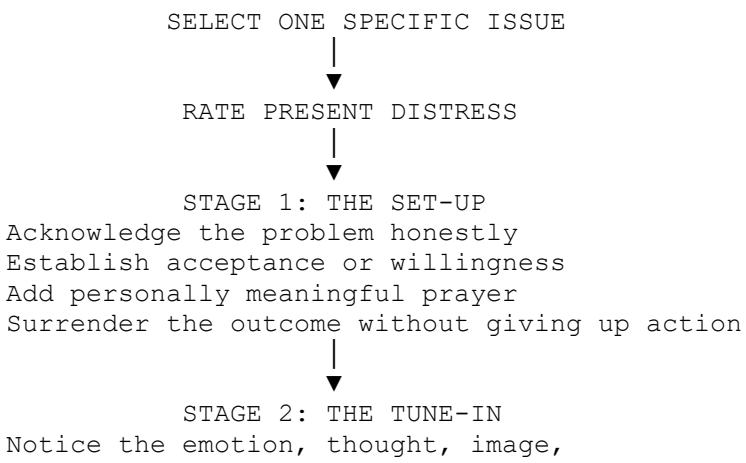
The three stages should not be treated as unrelated exercises. They form a continuous process:

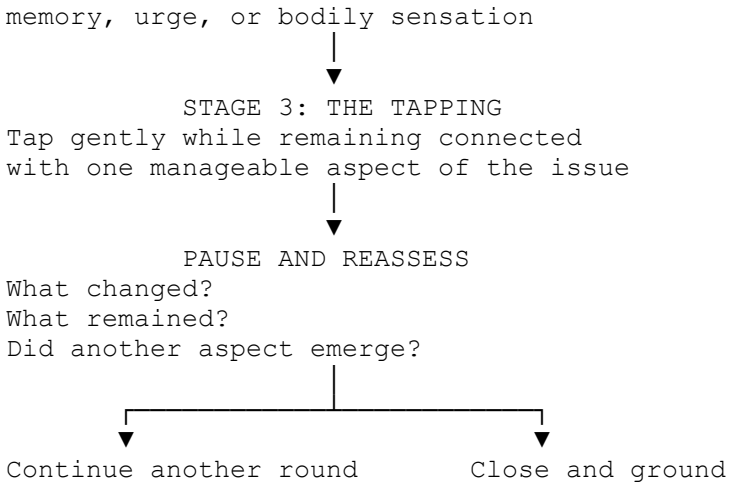
- The **set-up** establishes the emotional and spiritual position.
- The **tune-in** identifies what requires attention.
- The **tapping** provides rhythmic physical stimulation while that experience remains gently present.

The process may be represented as follows.

Figure 4

The Three Core Stages of SEFT





A single round may take only a few minutes. Complex emotional work, however, may require several rounds, more than one session, or another form of professional treatment.

5.1 Stage One: The Set-Up

The set-up prepares the individual to approach the selected issue with honesty and reduced internal resistance.

A set-up statement generally contains three elements:

1. acknowledgement of the specific difficulty;
2. acceptance, compassion, or willingness;
3. a spiritual intention or request, when desired.

A useful basic structure is:

"Even though I feel _____ when I think about _____, I acknowledge what I am experiencing, and I ask for _____."

For example:

"Even though I feel tightness in my chest when I think about tomorrow's interview, I acknowledge this anxiety, and I ask Allah for steadiness, clarity, and the ability to do my best."

This statement does not deny anxiety. It also does not predict that the interview will have a particular outcome. It recognizes the present experience and requests qualities that may support responsible action.

5.2 Why the Set-Up Begins with the Problem

People sometimes assume that emotional regulation requires immediate positive thinking. They may try to replace fear with confidence, sadness with happiness, or anger with forgiveness before the original emotion has been acknowledged.

This often produces language that feels false:

“I am completely confident.”

“I am no longer angry.”

“Everything is perfect.”

When the person does not believe the statement, repeating it may create further internal conflict.

The set-up begins with what is presently true:

“I am afraid.”

“I feel hurt.”

“Part of me is angry.”

“I do not know how to accept what happened.”

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This is not pessimism. It is emotional accuracy.

A credible statement creates a stronger foundation than a dramatic affirmation that the individual cannot accept.

5.3 Where the Set-Up Is Performed

Traditional EFT commonly uses the fleshy outer edge of the hand, often called the **side-of-hand** or **karate-chop point**, during the set-up. Some traditional SEFT descriptions also refer to gently pressing or rubbing an upper-chest location known in the method as the *sore spot*.

For self-practice, the side of the hand is usually simpler and less intrusive. The person taps it gently with the fingertips of the opposite hand while repeating the set-up statement.

Many protocols repeat the statement three times. The number is a procedural convention rather than a requirement supported by a known biological law.

The person should not strike, bruise, or create pain. Tapping should remain light and comfortable. Locations that are painful, medically restricted, inaccessible, or covered by medical equipment may be omitted. Clinical educational guidance from the Children’s Hospital of Philadelphia similarly advises users to skip any tapping location that is uncomfortable or obstructed.

5.4 The Four-Part Spiritual Set-Up

For individuals who want explicit spiritual integration, the set-up may be organized around four movements.

1. Honest Acknowledgement

The person names the experience without exaggeration or denial:

"I feel afraid when I remember the medical appointment."

2. Sincere Acceptance

The person acknowledges that the emotion is present:

"I accept that this fear is part of my experience at this moment."

This does not mean approving the situation or wanting the fear to remain.

3. Prayer or Spiritual Intention

The person asks for a quality, direction, or form of support:

"O Allah, grant me patience, courage, and clear judgment."

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4. Surrender of Outcome

The person recognizes the limits of control:

"I will take the responsible steps within my ability and place the final outcome in Your care."

A complete statement might therefore be:

"O Allah, even though I feel this fear in my stomach when I think about the test result, I sincerely acknowledge my present condition. Help me remain patient and make wise decisions. I will follow the medical advice available to me and surrender the final outcome to You."

This wording preserves both spiritual trust and personal responsibility.

5.5 Levels of Acceptance

Complete acceptance may not be immediately possible. The wording can be adjusted according to the person's actual readiness.

When Acceptance Feels Natural

"Even though I feel anxious, I accept that this is my present experience."

When Acceptance Feels Difficult

"Even though part of me resists this anxiety, I am willing to notice it without attacking myself."

When the Person Is Not Ready to Accept

"I am not ready to accept what happened, but I acknowledge that this pain is affecting me."

When Self-Acceptance Feels Unbelievable

"I am willing to treat myself with slightly more patience during this exercise."

When Forgiveness Is Premature

"I am not ready to forgive, but I am willing to reduce the hold this event has on my body and mind."

The set-up should describe a position the person can honestly occupy. Forced acceptance is another form of emotional pressure.

5.6 Set-Up Statements for Different Concerns

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Anxiety

"Even though I feel this pressure in my chest when I imagine speaking before the committee, I acknowledge my anxiety and ask Allah for steadiness and clear expression."

Anger

"Even though I feel intense anger when I remember how I was treated; I acknowledge that this anger is present. Help me protect my dignity without acting impulsively."

Grief

"Even though I feel this emptiness when I remember her absence, I honor the depth of this loss and ask for strength to carry my grief with patience."

Shame

"Even though I feel ashamed when I remember my mistake, I acknowledge the pain of it. May Allah help me take responsibility without reducing my entire identity to one action."

Physical Discomfort

"Even though I feel this tension in my shoulders, I acknowledge the discomfort and allow myself to become calmer while continuing to obtain the care I need."

Spiritual Struggle

"Even though part of me feels spiritually abandoned, I acknowledge this struggle honestly. I ask for guidance and the courage to seek understanding rather than condemn myself."

Secular Wording

"Even though I feel this fear when I imagine the meeting, I acknowledge my response and choose to approach the situation with steadiness and self-respect."

5.7 What the Set-Up Should Not Do

The set-up should not:

- guarantee healing;
- declare an unverified medical cause;
- pressure the person to forgive;
- require positive emotion;
- imply that distress reflects spiritual failure;
- replace practical action;
- describe the practitioner as a source of supernatural power;
- state that an energy blockage has been removed;
- demand complete acceptance when the person does not feel it.

A poorly constructed statement might be:

"Even though my cancer was caused by negative energy, I know tapping will heal me."

A safer statement is:

"Although this illness has brought fear and uncertainty, I acknowledge the emotional burden and ask for calmness while I continue my medical treatment."

5.8 Stage Two: The Tune-In

Tune-in means bringing gentle, deliberate attention to the chosen aspect of the problem.

The person may focus on:

- an emotion;
- a bodily sensation;
- a short memory scene;
- a mental image;

- a sentence spoken by someone;
- a feared future situation;
- an urge to act;
- a belief about the self;
- a spiritual struggle.

Tune-in does not require the person to become completely absorbed in the event. The purpose is to activate enough of the experience for it to be recognized and observed, while preserving present-moment awareness.

A person working with a workplace incident might notice:

“I can see my manager looking at me.”

“I hear the words, ‘You are not capable.’”

“My face becomes hot.”

“I want to leave the room.”

These are separate aspects of the same experience. They do not necessarily need to be processed simultaneously.

5.9 The Reminder Phrase

During tapping, a short reminder phrase helps maintain contact with the selected target.

Examples include:

“This fear in my chest.”

“That humiliating sentence.”

“The image of the hospital room.”

“This anger in my jaw.”

“The fear of being rejected.”

“This spiritual confusion.”

The reminder phrase is shorter than the set-up statement. It should identify the concern without requiring the person to repeat the entire history.

A spiritual reminder phrase might be:

"O Allah, this fear."

"This pain that I place before You."

"Help me remain present with this grief."

A neutral phrase might be:

"This remaining tension."

"This difficult memory."

"Part of me still feels unsafe."

5.10 Staying Within a Manageable Range

Tune-in should be strong enough for the person to notice the issue but not so intense that awareness of the present disappears.

The practitioner can ask:

"Are you still aware that you are sitting here with me?"

"Can you feel your feet on the floor while noticing the memory?"

"Would it feel safer to move further away from the image?"

"Do you want to work only with the title of the event?"

The person may imagine:

- viewing the event from a distance;
- seeing it on a small screen;
- placing it temporarily behind a closed door;
- working with only one second of the memory;
- using a neutral title instead of describing details.

For example:

"The incident in the blue room."

The practitioner does not need to know every detail for the person to maintain an internal focus.

5.11 Content-Free Tune-In

Some people do not wish to describe the event aloud. This preference should be respected.

The person may say only:

"There is an event I do not want to describe. When I think about it, the intensity is seven, and I feel pressure in my throat."

A set-up statement could be:

"Even though this private event brings pressure to my throat, I acknowledge my reaction and ask for enough safety to work with only what feels manageable."

The reminder phrase might be:

"This private event."

"This pressure in my throat."

"This remaining distress."

Content-free work protects privacy, but it does not automatically make severe trauma safe for self-treatment. The practitioner must still monitor orientation, intensity, choice, and emotional stability.

5.12 Tune-In for Physical Sensations

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When the target is physical discomfort, describe the sensation precisely:

- location;
- size;
- temperature;
- movement;
- pressure;
- shape;
- texture;
- intensity.

For example:

"A warm, tight band across the upper shoulders, intensity six."

After tapping, the person may notice that it:

- decreases;
- increases;
- moves;
- changes shape;
- becomes warmer or cooler;
- remains unchanged.

These changes are subjective observations. They do not establish the medical cause of the symptom.

5.13 Tune-In and Prayer

Prayer during tune-in should remain brief enough that attention does not move completely away from the issue.

Examples include:

"O Allah, You know this pain."

"Help me remain present."

"Grant me patience with this moment."

"Guide me towards the right action."

The prayer should not become a demand to suppress the emotion:

"I must not feel afraid because I have faith."

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A healthier spiritual position is:

"I can experience fear and still seek guidance, courage, and responsible action."

5.14 Stage Three: The Tapping Sequence

During the third stage, the individual taps gently through selected points while remaining connected with the target.

Shortened EFT sequences commonly include nine locations:

1. side of the hand;
2. top of the head;
3. beginning of the eyebrow;
4. side of the eye;
5. under the eye;
6. under the nose;
7. chin area;
8. collarbone area;
9. under the arm.

Some SEFT protocols describe a longer sequence of up to eighteen points, while other studies use shorter versions. One published SEFT protocol instructed participants to tap points lightly approximately five to seven times while maintaining tune-in and prayer. Because protocols differ, practitioners and researchers should document precisely which sequence they use.

The complete anatomical locations and extended sequence are presented in Chapter 6.

5.15 Tapping Pressure and Rhythm

Tapping should be:

- light;
- steady;
- comfortable;
- deliberate rather than hurried;
- strong enough to be felt but not painful.

Two or three fingertips may be used. The person can tap one side, both sides, or alternate sides according to comfort.

Exact counting is not essential in ordinary self-regulation practice. A person may tap each point for several seconds while saying one reminder phrase.

A simple rhythm is:

Tap gently while saying the phrase once.

Then move to the next point.

The person should not become so concerned with perfect counting that attention is removed from the emotional experience.

5.16 A Complete Basic SEFT Round

The following procedure is intended for a mild or moderate concern, not for an emergency or severe traumatic reaction.

Step 1: Select the Target

“The tightness in my chest when I think about tomorrow’s presentation.”

Step 2: Rate the Intensity

“Seven out of ten.” 7/10

Step 3: Form the Set-Up Statement

While tapping the side of the hand, repeat three times:

"Even though I feel this tightness in my chest when I imagine standing before the audience, I acknowledge my anxiety. O Allah, grant me steadiness, clear expression, and the ability to use my preparation well."

Step 4: Tune In

Pause briefly and notice:

- the imagined audience;
- the tightness in the chest;
- the thought, "I will make a mistake";
- the present distress level.

Step 5: Tap Through the Sequence

Top of head:

"This presentation anxiety."

Eyebrow:

"This tightness in my chest."

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Side of eye:

"I am afraid of making a mistake."

Under eye:

"I fear being judged."

Under nose:

"My body is preparing for danger."

Chin:

"This remaining anxiety."

Collarbone:

"O Allah, help me remain steady."

Under arm:

"I can feel anxiety and still speak carefully."

Top of head:

"I will prepare responsibly and surrender the outcome."

Step 6: Pause

Place the hands comfortably in the lap. Allow breathing to return to its natural rhythm.

Step 7: Reassess

Ask:

"When I imagine the presentation now, what number fits the intensity?"

Suppose the new rating is four.

The next round should focus on what remains:

"This remaining fear of forgetting my words."

The purpose is not to pressure the rating towards zero. The purpose is to observe honestly.

5.17 Complete Script: Anger After Disrespect

Target

A colleague made a dismissive comment during a meeting.

Initial Rating

Anger: 8 out of 10. "8/10"

Bodily Sensation

Heat in the face and tension in the jaw.

Set-Up

While tapping the side of the hand:

"Even though I feel intense anger when I remember that dismissive comment, I acknowledge the heat in my face and the tension in my jaw. O Allah, help me protect my dignity, communicate clearly, and avoid responding in a way I may regret."

Repeat three times, modifying the words when necessary.

Tapping Round

Top of head:

"This intense anger."

Eyebrow:

"That disrespectful comment."

Side of eye:

"I feel humiliated."

Under eye:

"My face becomes hot."

Under nose:

"Part of me wants to attack."

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Chin:

"I do not want to lose control."

Collarbone:

"This anger is telling me a boundary was crossed."

Under arm:

"I can listen to the anger without obeying every impulse."

Top of head:

"Guide me towards a firm and responsible response."

After the round, reassess:

- Has the anger decreased?
- Is humiliation now stronger than anger?
- Does the jaw feel different?
- Has a memory of earlier disrespect emerged?

- Is there a practical boundary that needs to be set?

A reduced anger rating does not mean that no response is required. Emotional regulation may make a more effective response possible.

5.18 Complete Script: Grief

Grief should not be approached as a symptom that must be eliminated. The aim may be to reduce one overwhelming wave of distress while respecting attachment and loss.

Target

The empty chair at the family dining table.

Set-Up

"Even though seeing the empty chair brings a heavy wave of grief, I honor the love and loss connected with this pain. O Allah, help me carry this moment with patience and tenderness."

Tapping Round

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Top of head:

"This heavy wave of grief."

Eyebrow:

"The empty chair."

Side of eye:

"I miss her presence."

Under eye:

"This heaviness in my chest."

Under nose:

"Part of me still expects her to be here."

Chin:

"This painful absence."

Collarbone:

"I do not have to erase my love."

Under arm:

"I ask for strength to carry this grief."

Top of head:

"One breath and one moment at a time."

The person may stop after one round. Grief work should not become a demand to reach zero distress.

5.19 Complete Script: Shame and Regret

Target

A mistake made during a professional presentation.

Set-Up

"Even though I feel ashamed when I remember losing my words during the presentation, I acknowledge the embarrassment. I am willing to learn from the experience without defining my whole professional identity by one moment."

Tapping Round

Top of head:

"This shame."

Eyebrow:

"I can see the audience watching me."

Side of eye:

"I believe they thought I was incompetent."

Under eye:

"This embarrassment in my face."

Under nose:

"I keep replaying the moment."

Chin:

"I made a mistake."

Collarbone:

"A mistake is not my complete identity."

Under arm:

"I can review what happened honestly."

Top of head:

"I can prepare differently next time."

5.20 Complete Secular Script

Target

Anxiety before a medical procedure.

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Set-Up

"Even though I feel anxious when I picture the procedure room, I acknowledge my fear. I am willing to support my body, ask the medical team the questions I need answered, and approach the experience one step at a time."

Reminder Phrases

"This procedure anxiety."

"This tension in my stomach."

"The fear of not being in control."

"I can ask questions."

"I can remain present."

"One step at a time."

Spirituality should never be added merely to make the method qualify as SEFT in name. When a participant prefers secular language, the ethical priority is respect for that preference.

5.21 What May Happen During a Round

After tapping, several outcomes are possible.

The Intensity Decreases

For example, the rating may move from seven to four.

Ask:

"What remains at four?"

Do not simply repeat the identical round. The remaining distress may concern a more specific aspect.

The Intensity Does Not Change

No change does not mean that the person has failed.

Possible explanations include:

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- the target is too broad;
- the wording does not fit;
- another emotion is more central;
- the person is not sufficiently connected with the issue;
- the person is overwhelmed or emotionally numb;
- the environment does not feel safe;
- the technique is not helpful for this person at this time.

Ask:

"Which part of the problem feels most active now?"

The Intensity Increases

An increase may occur because attention has moved closer to the painful material or another aspect has emerged.

Pause and assess:

- Is the person oriented?
- Does the person want to continue?
- Should the target be reduced?

- Is grounding required?
- Is professional referral indicated?

An increase should not automatically be described as a "healing crisis," "energy release," or proof that the method is working.

The Emotion Changes

Fear may shift to anger. Anger may reveal humiliation. Shame may reveal grief.

This is sometimes described as a change of aspect.

The next round should acknowledge the new emotion:

"Even though the fear has reduced, I now feel angry that I was left alone."

A Memory Emerges

A present concern may activate an earlier experience.

The person may realize:

"This criticism reminds me of being mocked at school."

The practitioner should not immediately enter the earlier memory. First assess whether it is safe and appropriate to continue.

The Body Sensation Moves

Pressure in the chest may become tension in the throat. This should be recorded as an observation rather than interpreted automatically as energy moving through the body.

Nothing Noticeable Happens

Some people experience no immediate change. They should not be blamed, encouraged to pretend, or told that unconscious resistance is preventing healing.

A respectful response is:

"Thank you for observing honestly. This method may not be producing a noticeable change right now."

5.22 The Testing Phase

After the intensity decreases, the person may gently test the change by returning to the original target.

Examples include:

- imagining the meeting again;
- repeating the upsetting sentence;
- looking at a relevant but non-overwhelming image;
- standing as though beginning a presentation;
- thinking about the next medical appointment.

Testing is not provocation. It should be gradual and consensual.

Ask:

"When you return to the original scene, what do you notice now?"

The person may discover that:

- the distress remains lower;
- another aspect appears;
- the original rating returns;
- the image feels more distant;
- the body feels calmer;
- the thought remains but has less emotional force.

A temporary reduction during tapping does not guarantee that the change will remain under real-life conditions.

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5.23 Introducing Constructive Language

Constructive or future-oriented statements are best introduced after the original emotion has been acknowledged.

Examples include:

"I may be able to take one manageable step."

"I can prepare without demanding perfection."

"I can set a boundary without becoming abusive."

"I can seek support."

"I am open to feeling slightly safer."

"I can allow calmness without denying what happened."

"I can trust God while continuing to act responsibly."

These statements are more credible than absolute claims such as:

“I will never feel anxious again.”

“Everyone will respect me.”

“Nothing can hurt me.”

“My illness is completely healed.”

Constructive language should expand choice, not replace reality.

5.24 Closing the Round

A SEFT session should not end while the person remains emotionally disorganized.

A closing sequence may include:

1. stop tapping;
2. place the hands comfortably;
3. notice the room;
4. feel the feet against the floor;
5. take a natural breath;
6. drink water if desired;
7. identify the present distress rating;
8. name one observation from the session;
9. identify any practical next step;
10. decide whether additional support is needed.

A brief closing statement might be:

“I acknowledge the work I have done today. I do not need to solve the whole issue in one session. I will take the next responsible step and allow the process to continue gradually.”

An Islamic version may be:

“Alhamdulillah for the strength to face this experience. O Allah, guide me towards the right action and protect me from placing a burden on myself beyond what I can manage.”

5.25 The Three Stages at a Glance

Stage	Primary purpose	Main question	Typical activity
Set-up	Establish honest acknowledgement and an accepting or spiritual position	“What am I experiencing, and how do I wish to meet it?”	Repeat a personalized statement while tapping the side of the hand

Tune-in	Maintain manageable contact with one aspect of the issue	"What emotion, thought, image, memory, or sensation is active now?"	Notice the target and use a brief reminder phrase
Tapping	Combine focused attention with rhythmic physical stimulation	"What changes while I remain gently connected with this experience?"	Tap through the selected sequence and reassess

5.26 Common Practice Errors

Using a Problem That Is Too Broad

Instead of:

"All my family problems."

Use:

"The sadness I felt when my opinion was ignored during Sunday's discussion."

Using Words Written by Someone Else

A script should be adapted to the individual's language. Words that sound impressive but feel unnatural can weaken emotional connection.

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Moving to Positivity Too Quickly

The person should not be rushed from:

"I am deeply hurt"

to:

"I am completely joyful."

A believable bridge is:

"I am willing to become slightly less overwhelmed."

Chasing a Zero Rating

A zero is not always necessary or appropriate. Grief, moral concern, and reasonable fear may remain present.

Interpreting Every Response Spiritually

Yawning, tears, warmth, fatigue, tingling, or emotional change may have several explanations. They should not automatically be called divine signs or proof of energy correction.

Repeating the Same Script Mechanically

After each round, ask what is present now. The wording should follow the person's current experience.

Ignoring Practical Problems

Tapping should not replace communication, medical care, protection, preparation, problem-solving, legal advice, or social support.

5.27 Chapter Summary

The three central stages of SEFT are set-up, tune-in, and tapping.

The set-up identifies the concern and establishes an attitude of acknowledgement, acceptance, willingness, prayer, or surrender. Tune-in maintains gentle contact with a specific emotion, memory, thought, image, or bodily sensation. Tapping introduces rhythmic physical stimulation while the issue remains within awareness.

The words should remain sincere. A person should not be required to claim complete acceptance, forgiveness, confidence, or faith when those states are not genuinely present. Spiritual surrender should coexist with responsible action.

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After each round, the person reassesses the experience. Distress may decrease, remain unchanged, increase, shift to another emotion, or reveal a different aspect. Every response should be observed without blame or exaggerated interpretation.

The three stages provide a structure, but the quality of SEFT depends on the care with which that structure is used.

Practice Worksheet

Selected issue:

Specific trigger:

Main emotion:

Body sensation:

Initial intensity:
_____ /10

My Set-Up Statement

"Even though _____
when I think about _____,
I acknowledge _____
and I ask for _____."

My Reminder Phrase

Words for the Tapping Round

Top of head:

Eyebrow:

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Side of eye:

Under eye:

Under nose:

Chin:

Collarbone:

Under arm:

Top of head:

Intensity after the round:
_____ /10

What changed:

What remains:

A new emotion, memory, thought, or sensation that appeared:

My next responsible step:

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Chapter 6

The Tapping Points

The physical component of SEFT involves gently tapping selected locations on the hand, face, head, and upper body while attention remains connected with a specific emotional concern. The points are traditionally explained through acupuncture meridians and the body's energy system. Those explanations form part of the historical model, but the existence of a measurable emotional "energy blockage" should not be presented as established anatomical fact.

For practical purposes, the points can be located through simple anatomical landmarks. The person does not need to strike an exact millimeter of skin or possess training in acupuncture. Tapping should remain gentle, respectful, and physically comfortable.

Two sequences are commonly encountered:

1. A **short core sequence**, closely related to modern EFT;
2. A **traditional extended SEFT sequence**, containing up to eighteen locations.

Modern EFT International materials identify nine principal locations: the side of the hand, top of the head, eyebrow, side of the eye, under the eye, under the nose, chin, collarbone, and underarm. Finger points and the gamut point are described as additional rather than essential locations.

Published SEFT procedures sometimes add a lower-chest point, inner and outer hand points, five finger points, and the gamut point. One published description of the extended SEFT sequence lists eighteen tapping locations, while another clinical study describes tapping the head, face, collarbone, underarm, lower chest, hands, fingers, side of the hand, and gamut point.

The variation means that the term *SEFT* does not always refer to one identical tapping sequence. Practitioners and researchers should state clearly which points were used.

6.1 Preparing the Hands

Before beginning:

- wash or sanitize the hands;
- remove rings or bracelets that interfere with movement;
- sit or stand in a stable position;
- relax the shoulders;
- identify any wounds, medical equipment, recent surgery, or painful areas;
- decide whether the right hand, left hand, or both hands will be used.

EFT International recommends clean hands and gentle tapping. Children's Hospital of Philadelphia advises users to skip points that are uncomfortable, inaccessible, or obstructed by medical equipment.

Most people use the pads of the index and middle fingers. Three or four fingers may be more comfortable when tapping broader locations such as the collarbone or side of the hand.

Tapping should not cause:

- sharp pain;
- bruising;
- skin damage;
- numbness;
- dizziness;
- pressure on the eyes;
- discomfort around a surgical or medical site.

Gentler contact, light pressure, or simply resting the fingertips on a point can be used when ordinary tapping is uncomfortable.

6.2 Pressure, Speed, and Number of Taps

Published SEFT procedures commonly describe approximately five to seven light taps at each location. Other instructional materials use about seven to ten taps or several seconds at each point.

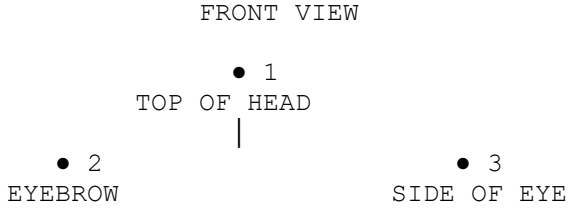
The exact number is less important than maintaining:

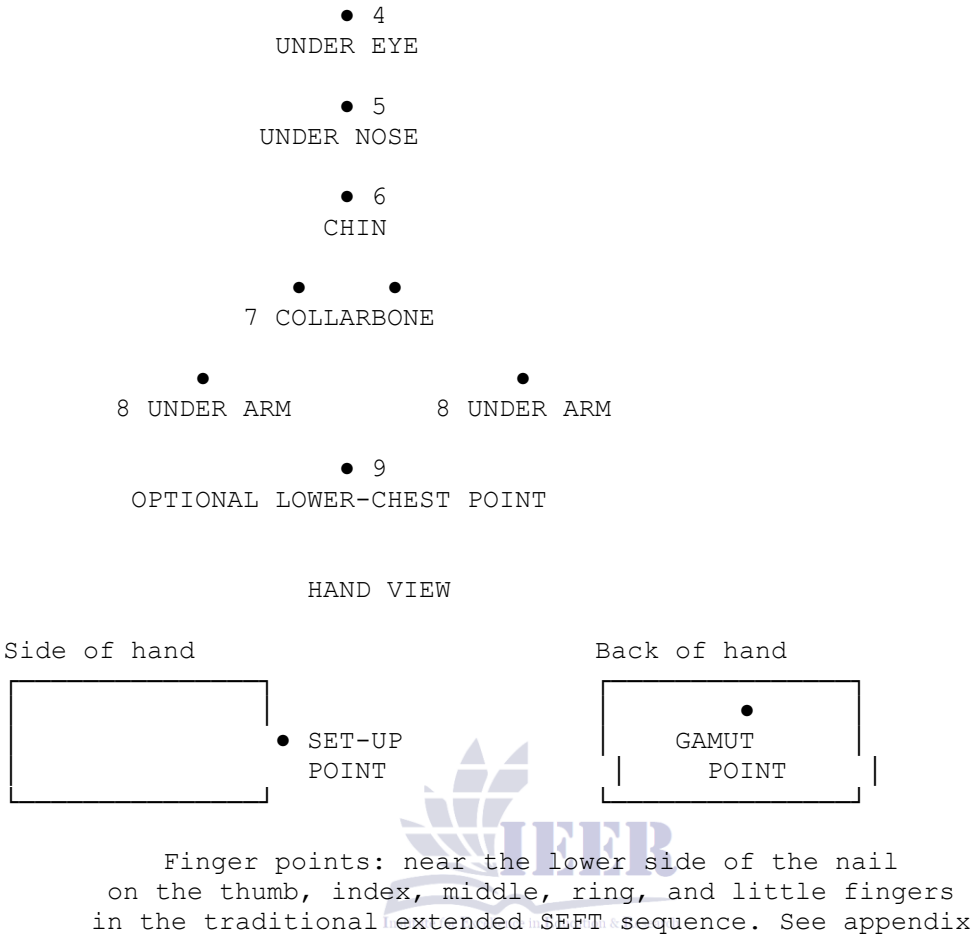
- a comfortable pressure;
- a steady rhythm;
- awareness of the selected issue;
- freedom to pause.

A suitable rhythm is approximately two or three taps per second. The person may tap each point while saying one reminder phrase and then move to the next location.

There is no need to tap harder when distress is intense. Emotional intensity is not corrected through physical force.

Figure 5: Core EFT and SEFT Tapping Map





Note. This is an educational location map, not an acupuncture chart. The lower-chest point is optional and should not be used in a way that compromises privacy, dignity, or physical comfort.

6.3 Point 1: Side of the Hand

Common abbreviations: SOH or KC
Traditional name: Side-of-hand or karate-chop point

Location

The point lies on the fleshy outer edge of the hand below the little finger, the area that might make contact during a karate-chop movement.

Use

This location is generally used during the set-up statement:

“Even though I feel this anxiety, I acknowledge what I am experiencing and ask for steadiness.”

The person taps the outer edge of one hand with the fingers of the opposite hand. Either hand may be used.

Practical Adaptation

A person with arthritis, hand pain, paralysis, tremor, or limited movement may:

- rub or tab the point gently;
- hold the outer edge of the hand;
- tap the wrist;
- use another comfortable point;
- imagine the tapping while repeating the statement.

The side-of-hand point is part of the principal EFT sequence and is also included near the end of the traditional eighteen-point SEFT sequence.

6.4 Point 2: Top of the Head

Abbreviation: TOH or Cr
Traditional SEFT term: Crown

Location

The point is near the center of the crown of the head.

Use two or three fingertips and tap gently. Do not strike the skull forcefully.

Example Reminder Phrase

“This remaining pressure.”

Or:

“O Allah, help me remain present.”

Adaptations

Avoid tapping directly over:

- a recent head injury;
- a surgical site;
- tender swelling;
- a wound;
- medical dressings.

A hand can be held several centimeters above the head, or another point may be substituted.

6.5 Point 3: Eyebrow

Abbreviation: EB

Location

The point lies at the beginning of the eyebrow, close to the bridge of the nose.

The fingertips should rest on the eyebrow bone rather than pressing into the eye socket.

Example Reminder Phrase

“This worry about tomorrow.”

The person may tap one eyebrow or touch both eyebrow points simultaneously. Comfort and ease are more important than strict side selection.

6.6 Point 4: Side of the Eye

Abbreviation: SE

Location

The point lies on the bone at the outer side of the eye, near the temple.

Tap on the bone, not on the eyeball or soft eye tissue.

Example Reminder Phrase

“I am afraid of being judged.”

Caution

People with recent eye surgery, facial injury, severe headache, or unusual visual symptoms should avoid uncomfortable facial tapping and obtain appropriate medical advice where necessary.

6.7 Point 5: Under the Eye

Abbreviation: UE

Location

The point lies on the upper cheekbone directly beneath the centre of the eye.

Tap lightly on the bone. Avoid pulling the lower eyelid or pressing upwards into the eye.

Example Reminder Phrase

"This fear in my body."

Published EFT charts place both the side-of-eye and under-eye locations on the bone surrounding the eye rather than on the eye itself.

6.8 Point 6: Under the Nose

Abbreviation: UN

Location

The point lies between the base of the nose and the upper lip.

Example Reminder Phrase

"Part of me still feels unsafe."

Facial tapping should remain light. A person using oxygen tubing, a mask, nasal equipment, or a medical dressing may omit this point.

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6.9 Point 7: Chin Point

Abbreviation: CH

Location

The point is in the indentation between the lower lip and the chin. Despite its name, it is not located on the lowest part of the chin.

Example Reminder Phrase

"This remaining sadness."

Avoid tapping irritated skin, active infection, or a recent dental or facial surgical area.

6.10 Point 8: Collarbone

Abbreviation: CB

Location

The point lies just below the inner end of the collarbone, a short distance to either side of the upper sternum.

The person may use two or three fingertips on one side or an open hand over a broader upper-chest area.

Example Reminder Phrase

"I acknowledge this emotional pressure."

Or:

"O Allah, grant me patience and wisdom."

The collarbone point should not become an excuse for unnecessary practitioner touch. Participants should normally locate and tap the point on themselves.

6.11 Point 9: Under the Arm

Abbreviation: UA

Location

The point is on the side of the torso, approximately a hand-width below the armpit. Some instructions describe it as the level of the middle of a bra strap. CHOP places it approximately four inches below the center of the armpit.

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Example Reminder Phrase

"This tension I have been carrying."

Privacy and Comfort

The person should tap themselves. In mixed-gender groups, online teaching, or culturally sensitive settings, the facilitator may demonstrate the location on their own upper side torso without asking participants to expose any part of the body.

A person may tap slightly higher, slightly lower, or omit the point when it feels awkward.

6.12 Optional Lower-Chest Point

Traditional SEFT abbreviation: BN
Common translation: Below nipple

Location

Traditional descriptions place this point on the lower chest or upper rib area below the nipple line. Published descriptions vary according to body anatomy, sex, clothing, and the source being followed.

Professional Recommendation

This point is optional.

It should be omitted when it:

- causes embarrassment;
- conflicts with cultural or religious boundaries;
- requires exposure;
- is near breast surgery, a mastectomy site, a wound, or medical device;
- creates uncertainty about consent;
- is unnecessary for the selected short sequence.

A practitioner should not touch this area. The participant may self-tap over clothing, use a nearby comfortable rib point, return to the collarbone point, or omit the location completely.

No person should be told that the procedure will fail because this point was skipped.

6.13 The Short Core Sequence

The short sequence is appropriate for introductory practice, self-regulation, group teaching, and many lower-intensity concerns.

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Set-Up Point

1. Side of hand

Tapping Sequence

2. Top of head
3. Eyebrow
4. Side of eye
5. Under eye
6. Under nose
7. Chin
8. Collarbone
9. Under arm

The person can then return to the top of the head or side of the hand before pausing and reassessing.

A complete short round may sound like this:

Side of hand:

“Even though I feel anxious about tomorrow’s meeting, I acknowledge this anxiety and ask Allah for steadiness and clear judgment.”

Top of head:

"This meeting anxiety."

Eyebrow:

"I am afraid of being criticized."

Side of eye:

"This fear of humiliation."

Under eye:

"This tension in my face."

Under nose:

"Part of me wants to avoid the meeting."

Chin:

"This remaining anxiety."

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Collarbone:

"I can prepare and respond carefully."

Under arm:

"I ask for steadiness and wisdom."

Top of head:

"I will do what is within my ability and surrender the outcome."

Modern EFT International instructions use the same central head, face, collarbone, and underarm sequence, with the side of the hand used during set-up.

6.14 The Traditional Extended SEFT Sequence

The extended sequence reported in SEFT literature may contain the following eighteen locations:

No.	Abbreviation	Point
1	Cr	Crown or top of head
2	EB	Beginning of eyebrow

3	SE	Side of eye
4	UE	Under eye
5	UN	Under nose
6	CH	Chin point
7	CB	Collarbone
8	UA	Under arm
9	BN	Optional lower-chest point
10	IH	Inside of hand
11	OH	Outside of hand
12	Th	Thumb
13	IF	Index finger
14	MF	Middle finger
15	RF	Ring finger
16	BF	Little or baby finger
17	KC	Side-of-hand point
18	GS	Gamut point

This full list appears in published descriptions of traditional SEFT.

The short version commonly ends after the lower-chest point, while the extended version continues through the hand and finger points. Some traditional descriptions then use the nine-gamut procedure before repeating the principal sequence.

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6.15 Inside and Outside of the Hand

Inside of Hand

Traditional SEFT descriptions place this point on the inner hand or wrist–palm border. Exact diagrams vary across sources.

Outside of Hand

This point is located on the outer border of the hand near the junction with the palm.

Because these locations are described inconsistently, practitioners should follow one clearly documented training manual rather than combining several diagrams without explanation.

Neither point is essential to the modern short EFT sequence.

6.16 Finger Points

Traditional extended SEFT uses points near the lower edge of the nail on:

- the thumb;
- index finger;
- middle finger;
- ring finger;
- little finger.

The person may tap the side of each finger near the nail with the fingertips of the opposite hand.

The contemporary EFT International chart identifies the thumb, index, middle, and little-finger points as optional additions; it does not include the ring-finger point in its modern finger sequence. Traditional SEFT descriptions, however, commonly include the ring finger.

This difference should be recorded when the protocol is used in research.

6.17 The Gamut Point

Abbreviation: GS

Location

The gamut point lies on the back of the hand between and slightly behind the knuckles of the ring and little fingers.

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To find it:

1. place the hand palm-down;
2. identify the knuckles of the ring and little fingers;
3. move slightly towards the wrist;
4. tap gently in the space between the two hand bones.

EFT International describes the gamut point as an additional location rather than part of the short core sequence.

6.18 The Nine-Gamut Procedure

The traditional extended procedure sometimes combines continuous tapping on the gamut point with a sequence of eye movements, humming, and counting.

One commonly reported version is:

1. close the eyes;
2. open the eyes;
3. look down towards one side without moving the head;
4. look down towards the opposite side;
5. circle the eyes slowly in one direction;
6. circle them in the opposite direction;

7. hum briefly;
8. count from one to five;
9. hum briefly again.

Afterwards, the person may repeat the tapping sequence from the top of the head through the side of the hand.

Cautions

The nine-gamut procedure is optional. It should be stopped if it produces:

- dizziness;
- nausea;
- visual discomfort;
- headache;
- confusion;
- emotional disorientation.

The person should not make rapid or forceful eye movements.

Some SEFT papers relate these eye movements to EMDR. The nine-gamut procedure should not, however, be described as EMDR therapy. EMDR is a comprehensive psychotherapy with history-taking, preparation, assessment, desensitization, installation, body scan, closure, and reevaluation phases; it is not defined by eye movements alone.

Practitioners who are not trained in EMDR should not advertise the gamut procedure as an abbreviated form of EMDR trauma treatment.

6.19 Which Side Should Be Tapped?

The head, facial, collarbone, and underarm locations are present on both sides of the body. In ordinary practice, the person may:

- tap the right side;
- tap the left side;
- tap both sides simultaneously;
- change sides during the round.

The choice should be based on physical comfort, mobility, pain, medical restrictions, and ease of movement.

A person with weakness after stroke, unilateral injury, an intravenous line, surgery, or limited hand movement should use the accessible side. A participant should not be required to perform symmetrical movements.

6.20 Is the Exact Sequence Essential?

The short core sequence provides an orderly routine and reduces the burden of remembering many points. It is useful to follow a consistent order during learning and research.

At the same time, the sequence should not become rigid. A point may be:

- omitted because of pain;
- replaced with another comfortable point;
- tapped for longer;
- revisited because it feels settling;
- held rather than tapped.

CHOP explicitly advises that uncomfortable or inaccessible locations may be skipped, including locations obstructed by medical equipment.

The person's physical safety is more important than completing every location.

6.21 Adaptations for Physical Conditions

Arthritis or Hand Pain

Use:

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- fewer fingers;
- a softer touch;
- gentle rubbing;
- palm-to-palm pressure;
- imagined tapping;
- a practitioner-led verbal exercise without physical tapping.

Shoulder Limitation

Use the hand that moves most easily. Skip the underarm point when reaching causes pain.

Facial Sensitivity

Use very light touch, tap nearby, hold the point, or omit facial locations.

Headache or Migraine

Do not assume that tapping is medically appropriate for every headache. New, severe, sudden, or unusual headache requires appropriate assessment. If ordinary tapping worsens discomfort, stop.

Stroke or Neurological Disability

The participant may use the unaffected hand, tap only accessible points, receive verbal assistance, or use imagined movement. Tapping must not replace rehabilitation, neurological treatment, medication, or medical monitoring.

Pregnancy

Use comfortable upper-body and hand points without pressure on sensitive areas. Pregnancy-related pain, bleeding, severe headache, swelling, reduced fetal movement, or other concerning symptoms require appropriate maternity care rather than self-treatment alone.

Skin Conditions

Do not tap directly on:

- open wounds;
- active infection;
- burns;
- inflamed skin;
- painful rashes;
- recent surgical incisions.

A nearby location or non-contact alternative may be used.

Medical Equipment

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Avoid disturbing:

- intravenous lines;
- oxygen tubing;
- cardiac monitors;
- ports;
- drains;
- dressings;
- braces;
- feeding tubes.

The relevant point may simply be skipped.

6.22 Adaptations for Sensory Preferences

Not everyone finds repetitive tapping soothing. Some people experience it as irritating, distracting, or overstimulating.

Alternatives include:

- holding each point;

- applying gentle circular pressure;
- placing a hand over the upper chest;
- tapping the fingertips together;
- alternating light taps on the thighs;
- imagining the sequence;
- using slow breathing without tapping;
- discontinuing the method.

The participant does not need to tolerate unpleasant sensory stimulation to prove willingness or sincerity.

6.23 Tapping with Children

Children should receive a simple explanation and retain the right to decline. A parent or practitioner may demonstrate on themselves while the child follows.

Language should remain brief:

“Even though I feel nervous about the injection, I know I can ask for help.”

The child may tap:

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- the side of the hand;
- top of the head;
- eyebrow;
- cheek;
- collarbone;
- hands or fingertips.

Children’s Hospital of Philadelphia presents a nine-location tapping exercise for distress and advises that uncomfortable points can be skipped.

Adults should take permission to touch a child’s face, chest, or body. Consent, safeguarding rules, parental involvement, developmental ability, and professional scope must be considered.

6.24 Group Demonstration

During a group exercise, the facilitator should:

1. demonstrate every point on their own body;
2. explain that participants may remain seated;
3. allow participants to keep personal issues private;
4. make the underarm and lower-chest locations optional;
5. avoid walking around and correcting bodies physically;
6. provide a stop or grounding option;
7. remind participants that exact imitation is unnecessary.

A group exercise should use a low-intensity target such as ordinary tiredness, mild nervousness, or general tension. Severe trauma should not be activated merely to demonstrate the tapping points.

6.25 Tapping Point Practice without an Emotional Target

Before using the points with distressing material, the learner can practice the physical sequence using a neutral phrase.

Practice Phrase

"I am learning these points slowly and comfortably."

Tap:

1. side of hand;
2. top of head;
3. eyebrow;
4. side of eye;
5. under eye;
6. under nose;
7. chin;
8. collarbone;
9. under arm.

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Then place the hands in the lap and notice:

- whether the pressure was comfortable;
- which hand was easier to use;
- whether any point felt sensitive;
- whether the sequence was easy to remember;
- whether another adaptation is needed.

This practice separates physical learning from emotional activation.

6.26 Core and Extended Versions Compared

Feature	Short core sequence	Extended SEFT sequence
Approximate locations	8 sequence points plus set-up point	Up to 18 points
Main areas	Head, face, collarbone, underarm	Core areas plus lower chest, hands, fingers, and gamut
Typical use	Introductory practice, brief self-regulation, groups	Traditional or fully documented SEFT procedure
Time required	Usually shorter	Usually longer
Gamut procedure	Not required	May be included

Sensitive chest point	Usually omitted	Traditionally included but optional
Research reporting	State the short sequence used	List all points and gamut procedures
Physical flexibility	Points may be skipped or adapted	Points may be skipped or adapted

6.27 Chapter Summary

The tapping points provide the physical structure of SEFT, but they should not be used rigidly or without regard for personal boundaries.

The short sequence uses the side of the hand, top of the head, eyebrow, side of the eye, under the eye, under the nose, chin, collarbone, and underarm. Traditional extended SEFT may add a lower-chest point, inner and outer hand points, five finger points, the side of the hand, and the gamut point.

The lower-chest point is optional and should never compromise privacy or dignity. Eye and facial points should be tapped on the surrounding bone rather than on the eyeball or delicate tissue. Medical equipment, wounds, painful areas, and inaccessible locations should be avoided.

The nine-gamut procedure is also optional. Although it uses eye movements, it is not equivalent to EMDR therapy.

Tapping should remain light, comfortable, and adaptable. The success of a SEFT exercise should not be judged by physical precision or completion of every point. Emotional awareness, consent, spiritual authenticity, and safety remain more important than a perfect sequence.

Tapping-Point Practice Record

Date:

Sequence practiced:
☐ Short core sequence
☐ Extended sequence
☐ Adapted sequence

Hand used:
☐ Right ☐ Left ☐ Both ☐ Alternating

Points that felt comfortable:

Points that were difficult to reach:

Points omitted because of pain, privacy, or medical reasons:

Adaptations used:

Reminder phrase:

Intensity before practice:
_____ /10

Intensity after practice:
_____ /10

Physical or emotional changes noticed:

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The sequence I will use in future practice is:

Chapter 7

Developing Effective SEFT Statements

Words give direction to a SEFT session. Tapping provides the physical rhythm, but the statement identifies the emotional target, acknowledges the person's present experience, and expresses the attitude with which that experience will be approached.

An effective statement is not necessarily elegant, positive, or spiritually impressive. It is effective when it is:

- specific enough to identify the concern;
- emotionally truthful;
- understandable to the person using it;
- consistent with the person's beliefs;
- gentle enough to remain tolerable;
- open to change as the session progresses.

EFT International identifies the use of the client's own language and perspective as a core principle of practice. It also encourages attention to specific events and particular aspects rather than relying only on broad problem labels.

A practitioner should therefore not arrive with a fixed script that is applied identically to every individual. Two people may experience the same event in very different ways. One person may feel anger, another may feel shame, and a third may feel relief mixed with guilt. The statement should reflect the meaning of the event for that particular person.

7.1 The Purpose of Words in SEFT

SEFT statements may perform several functions:

1. **Identifying the emotional target**
2. **Naming the current emotion or bodily response**
3. **Acknowledging the person's interpretation**
4. **Reducing self-judgment**
5. **Maintaining attention during tapping**
6. **Expressing prayer or spiritual intention**
7. **Supporting a responsible next step**
8. **Distinguishing what can and cannot be controlled**

Putting an emotional experience into words may itself contribute to regulation. Experimental research on affect labelling has found that naming emotions can sometimes reduce subjective or physiological responding, although the effects vary by context, timing, intensity, and research design. It should therefore be regarded as a potentially helpful process rather than a guaranteed response.

Words should help the person contact the experience without becoming submerged in it.

For example:

“I am a complete failure.”

This statement merges the person’s entire identity with a painful conclusion.

A more workable statement is:

“Part of me believes I failed because my application was rejected.”

The second version creates psychological distance. It recognizes the belief without declaring it to be the complete truth about the person.

7.2 Three Main Types of SEFT Statements

A SEFT session generally uses three forms of language.

1. The Set-Up Statement

The set-up statement is used at the beginning of a round, usually while tapping the side of the hand.

It contains a fuller description:

“Even though I feel humiliated when I remember my colleague interrupting me during the meeting, I acknowledge this hurt and ask Allah for steadiness and wisdom in deciding how to respond.”

2. The Reminder Phrase

The reminder phrase is used while tapping through the points.

It is short:

“This humiliation.”

“That interruption.”

“This pressure in my chest.”

The phrase helps the person remain connected with the selected aspect.

3. The Integration or Choice Statement

An integration statement may be introduced later, after the original distress has been acknowledged.

It supports a possible direction:

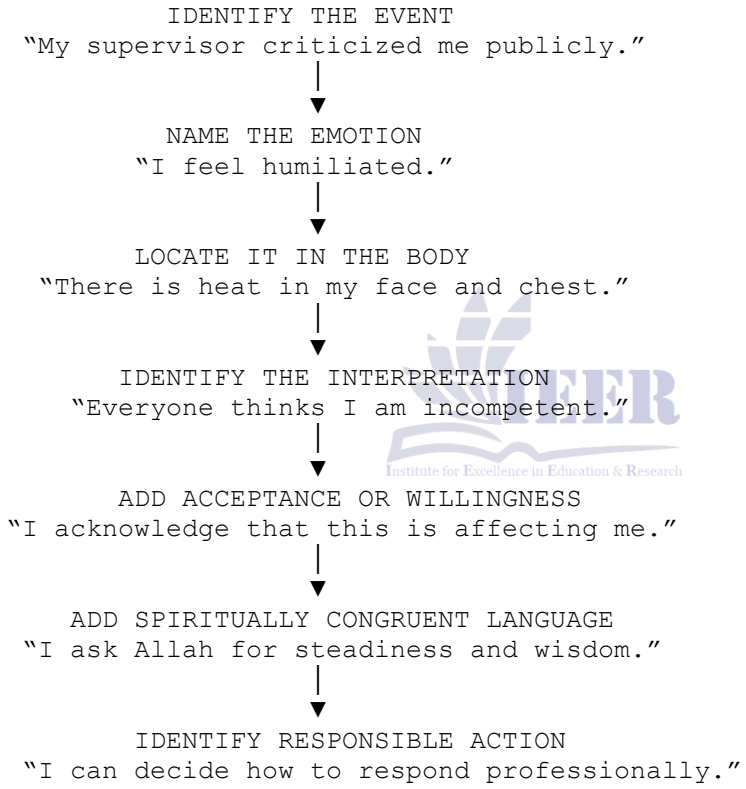
“I can remain calm and still speak firmly.”

“I am willing to prepare without demanding perfection.”

“I can trust Allah while taking the actions within my responsibility.”

The three types of language should not be confused. The set-up describes the issue. The reminder phrase maintains focus. The integration statement supports a credible next position.

Figure 6: The Progression of a SEFT Statement



The process is not a rigid formula. A statement may include only the elements that are relevant and emotionally manageable.

7.3 Begin with a Specific Event

Statements such as the following are usually too broad:

“Even though I have anxiety…”

“Even though my family has hurt me…”

"Even though I have low self-esteem…"

"Even though I am always angry…"

Each phrase may refer to numerous events, beliefs, emotions, and relationships.

A more specific statement identifies one moment:

"Even though I feel anxious when I picture entering the interview room tomorrow…"

"Even though I feel hurt when I remember my sister saying that I had contributed nothing to the family…"

"Even though I felt ashamed when I forgot my words during last week's lecture…"

"Even though I feel anger when I remember being excluded from Monday's decision…"

EFT teaching materials similarly recommend moving from global problems to specific events and then identifying the most emotionally active aspect of the event.

From Global to Specific

Global description	More specific focus
"My fear of authority"	"The expression on the dean's face when I entered the office"
"My difficult childhood"	"The evening my father tore up my school certificate"
"My marriage problems"	"The sentence my husband used during Sunday's argument"
"My medical anxiety"	"The image of waiting for the laboratory result"
"My lack of confidence"	"The moment I lost my words during the presentation"
"My grief"	"Seeing her empty chair at breakfast"
"My anger towards my family"	"Being excluded from the inheritance discussion"

Specificity does not mean that the event is unimportant. It means that the event is divided into a form that can be approached and assessed.

7.4 Identify the Active Aspect

A single event may contain several emotional aspects.

Suppose a woman recalls being criticized during a family gathering. The active aspects may include:

- the exact words spoken;
- the tone of voice;
- the relatives who remained silent;
- the belief that her husband failed to protect her;

- heat in her face;
- the urge to leave;
- a memory of earlier humiliation;
- fear that the incident will occur again.

The practitioner may ask:

“Which part feels strongest at this moment?”

“Is it the comment itself or the fact that nobody defended you?”

“What image appears first?”

“Where do you feel it in your body?”

“What does that moment seem to say about you?”

The next tapping round should focus on the aspect that is presently active rather than trying to include every part of the event in one long statement.

7.5 Use the Person’s Own Language

A practitioner may help organize a statement, but the central words should come from the person.

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Suppose the person says:

“I felt as if I had disappeared from the room.”

The practitioner should not automatically replace this with:

“You experienced rejection-based cognitive distortion.”

The person’s phrase may contain greater emotional meaning:

“Even though I felt as if I had disappeared from the room when nobody responded to me, I acknowledge how painful that was.”

The practitioner can check:

“Does the word ‘disappeared’ fit, or would another word be more accurate?”

Using the person’s language supports autonomy and reduces the risk that the practitioner will impose an interpretation. EFT International’s professional guidance similarly emphasizes client language, perspective, beliefs, culture, and tradition.

7.6 Emotional Accuracy

The correct emotion is not always the first one named.

A person may initially say:

“I am stressed.”

Further exploration may reveal:

- fear;
- humiliation;
- anger;
- guilt;
- helplessness;
- resentment;
- grief;
- disappointment;
- loneliness.

The practitioner should not insist on a particular label. A tentative question is preferable:

“Does this feel more like fear, humiliation, anger, or something else?”

The person may also experience mixed emotions:

“I am angry that she left, but I also miss her.”

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A statement can acknowledge both:

“Even though I feel angry about the way she left and deeply sad about losing the relationship, I acknowledge that both emotions are present.”

Mixed emotions do not need to be simplified artificially.

7.7 Describe the Bodily Experience

When the person notices a clear physical component, it can be included:

“This tightness in my throat.”

“This heavy pressure behind my eyes.”

“This heat in my face.”

“This hollow feeling in my stomach.”

“This tension across my shoulders.”

A fuller set-up might be:

"Even though I feel this tightness in my throat when I think about speaking to the committee, I acknowledge my fear and ask for steadiness."

The description should remain observational. It should not assume an unverified cause.

Avoid:

"This blocked energy in my liver caused by anger."

Use:

"This heaviness I notice in my upper abdomen when I think about the argument."

The second statement reports the person's experience without presenting a medical or energetic conclusion as fact.

7.8 Separate the Person from the Emotion

Statements beginning with "I am" can sometimes make a temporary experience sound like a complete identity:

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"I am weak."

"I am broken."

"I am unworthy."

"I am a failure."

A useful modification is:

"Part of me feels weak."

"I feel emotionally exhausted."

"I carry the belief that I am unworthy."

"Part of me interprets this rejection as proof that I failed."

EFT practitioners sometimes use phrases such as "something in me" or "a part of me" to make difficult experiences easier to approach without denying them.

This form of language does not deny responsibility. It distinguishes an emotion, thought, or behavior from the whole person.

For example:

“Part of me acted selfishly in that situation, and I need to take responsibility.”

This is different from:

“I am entirely selfish and undeserving of respect.”

7.9 Acceptance Language

Acceptance in SEFT means acknowledging the present experience. It does not mean approving the event, abandoning change, or agreeing with another person’s harmful behavior.

Contemporary psychological literature describes acceptance through processes such as acknowledging, allowing, non-judging, and remaining open to present experience.

Acceptance language can be adjusted according to readiness.

Full Acceptance

“I acknowledge and accept that this fear is present right now.”

Partial Acceptance

“I am willing to acknowledge part of this fear.”

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Willingness

“I am willing to notice this reaction for a few moments.”

Non-Judgment

“I can observe this emotion without calling myself weak.”

Compassion

“I am willing to respond to this pain with patience rather than criticism.”

When Acceptance Feels Impossible

“I do not accept what happened, but I acknowledge that it continues to affect me.”

When the Person Feels Angry About Having the Emotion

“Even though I am frustrated that I still feel afraid, I acknowledge both the fear and my frustration with it.”

The practitioner should not correct the person by saying:

“You must accept it completely before healing can occur.”

That statement creates pressure and may imply that a lack of improvement is the person’s fault.

7.10 Avoid Emotional Suppression

A statement should not command the person to stop having an emotion:

“I must not be angry.”

“I refuse to think about this.”

“I will remove every negative thought.”

“A faithful person should not feel fear.”

Research on deliberate thought suppression has found that attempts to force thoughts away can produce rebound effects in some circumstances.

A safer direction is:

“I can notice this angry thought without acting on it immediately.”

“I do not need to solve this fear by forcing it away.”

“I can have faith and still acknowledge that my body feels frightened.”

The objective is greater choice, not emotional censorship.

7.11 Writing Spiritually Integrated Statements

Traditional SEFT descriptions integrate prayer, sincerity, acceptance, and surrender during the set-up and tune-in stages. The person may acknowledge the difficulty while using language expressing trust in and surrender to God.

A spiritually integrated statement can include four elements:

Acknowledgement

“I feel fear about the medical result.”

Spiritual Relationship

“O Allah, You know this fear.”

Request

"Grant me patience, clear judgment, and the courage to seek appropriate care."

Surrender

"I will take the steps within my responsibility and entrust the final outcome to You."

The complete statement becomes:

"O Allah, even though I feel fear when I think about the medical result, I acknowledge this reaction honestly. Grant me patience and clear judgment. I will obtain the care I need and entrust the final outcome to You."

This language does not suggest that prayer replaces treatment. It connects prayer with responsible action.

7.12 Spiritually Respectful Language

Spiritual wording should:

- reflect the person's own beliefs;
- remain theologically modest;
- avoid claiming knowledge of divine intentions;
- support agency and ethical action;
- allow doubt or spiritual struggle to be expressed;
- avoid using faith as a measure of treatment compliance.

Appropriate wording may include:

"I ask Allah for guidance."

"I place what I cannot control in Allah's care."

"Help me act with patience and justice."

"I acknowledge that I do not understand this experience."

"I ask for mercy and the strength to repair what I can."

Inappropriate wording includes:

"God caused this illness because you were negative."

"If your faith is strong, the pain will disappear."

"You must forgive immediately to receive healing."

"This outcome is certainly God's plan for you."

"Your lack of improvement proves that you have not surrendered."

The practitioner does not have the authority to declare the divine meaning of another person's suffering.

7.13 Statements for Spiritual Struggle

Spiritual distress should be acknowledged rather than covered with devotional language.

Feeling Abandoned

"Even though part of me feels abandoned by Allah during this difficulty, I acknowledge this painful spiritual struggle. I ask for the courage to remain honest and seek understanding."

Anger Towards God

"Even though I feel anger and confusion about why this happened, I acknowledge that these feelings are present. I am willing to approach them with honesty rather than condemn myself."

Religious Guilt

"Even though I feel intense guilt when I think about my mistake, I ask for the wisdom to distinguish responsible remorse from destructive self-condemnation."

Difficulty Praying

"Even though I feel emotionally distant when I try to pray, I acknowledge this distance without forcing myself to pretend."

Fear of Punishment

"Even though part of me interprets every difficulty as punishment, I acknowledge how frightened this belief makes me and seek trustworthy spiritual and psychological guidance."

SEFT should not be used to settle theological questions outside the practitioner's competence. Collaboration with a religious scholar or spiritual-care professional may be appropriate when chosen by the participant.

7.14 Cultural Adaptation

Certain familiar EFT phrases may sound unnatural across languages or cultures. Statements such as "I deeply and completely love and accept myself" may be helpful for some individuals but uncomfortable or unbelievable for others.

EFT literature has long recommended adapting phrases to the individual's language, culture, and religious beliefs rather than forcing standard Western self-acceptance wording.

Alternatives include:

"I acknowledge what I am feeling."

"I am willing to treat myself with fairness."

"I accept that this is my present condition."

"I ask Allah to help me respond wisely."

"I honor my dignity despite this difficulty."

"I am open to learning from this experience."

Cultural adaptation is not achieved merely by translating words. The statement must also fit the person's understanding of selfhood, family, responsibility, spirituality, dignity, and emotional expression.

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7.15 The Language Ladder

People sometimes move too quickly from distress to an idealized positive statement.

For example:

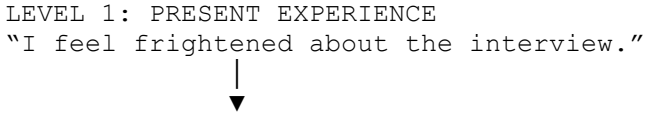
"I am terrified of the interview."

followed immediately by:

"I am completely confident and will succeed."

The second statement may feel false. A more credible progression uses small steps.

Figure 7: The SEFT Language Ladder



```
LEVEL 2: ACKNOWLEDGEMENT
"I acknowledge that this fear is present."
              |
              ▼
LEVEL 3: WILLINGNESS
"I am willing to remain with it for this moment."
              |
              ▼
LEVEL 4: SELF-SUPPORT
"I can prepare without attacking myself."
              |
              ▼
LEVEL 5: POSSIBILITY
"It is possible that I can manage part of this."
              |
              ▼
LEVEL 6: RESPONSIBLE ACTION
"I can answer one question at a time."
              |
              ▼
LEVEL 7: SPIRITUAL TRUST
"I will use my preparation and entrust the outcome to Allah."
```

Each step should be believable. The person does not have to reach the highest level during every session.

7.16 Bridging Statements

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A bridging statement connects the present emotional state with a possible but credible direction.

Examples include:

"I am not calm yet, but I am open to becoming slightly steadier."

"I do not trust this person, but I can trust myself to observe the situation carefully."

"I cannot forgive at this moment, but I am willing to reduce the harm this anger is causing me."

"I am still grieving, but I may be able to move through this hour."

"I remain uncertain, but I can gather the information I need."

"I cannot control the result, but I can prepare responsibly."

"I am afraid, and I can ask Allah for courage while taking the next step."

The word **and** is often more useful than **but** because it allows two realities to coexist:

"I feel anxious, and I can still speak."

"I am grieving, and I can care for myself today."

"I disagree with what happened, and I can regulate my response."

7.17 Choice Statements

A choice statement describes an action or attitude within the person's control.

Useful choices include:

"I choose to pause before answering."

"I choose to seek accurate information."

"I choose to establish a respectful boundary."

"I choose to speak without humiliation or aggression."

"I choose to prepare one section at a time."

"I choose to seek professional support."

Choice statements should not imply control over other people or uncertain outcomes.

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Avoid:

"I choose that my husband will change."

"I choose that the journal will accept my article."

"I choose that the medical result will be normal."

Use:

"I choose to communicate my needs clearly."

"I choose to revise the manuscript carefully and respond professionally."

"I choose to obtain the result, discuss it with my physician, and make an informed plan."

7.18 Statements for Anger

Anger statements should acknowledge both the emotion and the behavior the person wishes to choose.

Initial Statement

"Even though I feel intense anger when I remember being excluded from the decision, I acknowledge that a boundary was crossed."

Body-Focused Phrase

"This heat in my face and tension in my hands."

Underlying Emotion

"Beneath the anger, I feel unimportant and rejected."

Responsible Direction

"I can communicate firmly without threatening or humiliating anyone."

Spiritual Integration

"O Allah, help me seek justice without becoming unjust in my own response."

A spiritually framed anger statement should never pressure the person to become passive in the face of mistreatment.

7.19 Statements for Anxiety

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General Anxiety

"Even though I feel unsettled and do not yet understand the cause, I acknowledge this discomfort and am willing to remain with one small part of it."

Future Fear

"Even though I imagine the worst outcome, I acknowledge how frightened this image makes me."

Performance Anxiety

"Even though I fear forgetting my words, I can rely on my preparation and speak one sentence at a time."

Health Anxiety

"Even though I am afraid that this symptom means something serious, I will seek appropriate medical advice rather than rely only on fear or reassurance."

Spiritual Wording

"I ask Allah for calmness, accurate understanding, and the strength to act responsibly."

7.20 Statements for Grief

The goal of grief statements is not to remove attachment or demand emotional closure.

Loss

"Even though I feel this deep emptiness when I remember his absence, I acknowledge the love and loss contained in this grief."

Anniversary Reaction

"Even though this date brings the pain back strongly, I allow myself to move through today gently."

Unfinished Communication

"Even though I regret the words I never said, I acknowledge this regret and seek a meaningful way to express what remains."

Spiritual Grief

"O Allah, I do not fully understand this loss. Help me carry it with patience without denying how deeply it hurts."

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Continuing Life

"Continuing my life does not mean that the person was unimportant."

Grief should not be framed as a failure when distress remains after tapping.

7.21 Statements for Shame and Guilt

Shame and guilt should be distinguished.

Guilt often concerns behavior:

"I did something wrong."

Shame concerns the whole self:

"I am wrong, defective, or unworthy."

Responsible Guilt

"Even though I regret what I did, I am willing to take responsibility and consider how to repair the harm."

Excessive Guilt

"Even though I blame myself for everything that happened, I am willing to examine which parts were and were not within my control."

Shame

"Even though I feel that this mistake defines me, I acknowledge the shame and remain open to seeing myself as more than one action."

Spiritual Guilt

"I ask for forgiveness, guidance, and the courage to make amends where possible."

Spiritual language should not be used to remove accountability:

"God has forgiven me, so I do not need to repair the harm."

Nor should it be used to create endless punishment:

"Because I made a mistake, I must suffer permanently."

7.22 Statements for Rejection

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Social Rejection

"Even though being excluded made me feel invisible, I acknowledge how painful that experience was."

Professional Rejection

"Even though the rejection letter activated the belief that I am not capable, I recognize that one decision does not define my entire professional value."

Relationship Rejection

"Even though part of me believes I was unlovable because the relationship ended, I acknowledge the grief and the conclusions I formed about myself."

Spiritual Support

"O Allah, help me preserve my dignity, learn what is useful, and release what is not within my control."

The statement should not minimize the practical consequences of rejection. It should help separate the event from global self-condemnation.

7.23 Statements for Physical Symptoms

Statements for physical discomfort should remain medically cautious.

Pain

"Even though I feel this aching pain in my lower back, I acknowledge the discomfort and allow my body to settle as much as it safely can."

Fatigue

"Even though I feel exhausted and frustrated by my limitations today, I am willing to listen to what my body needs."

Medical Procedure

"Even though I feel anxious about the procedure, I will ask questions, follow appropriate instructions, and support myself emotionally."

Chronic Illness

"Even though living with this condition has brought anger and grief, I acknowledge the emotional burden while continuing my medical care."

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Avoid:

"This tapping will cure the disease."

"My pain proves that I am holding resentment."

"I no longer need my medication."

SEFT statements may address emotional responses to symptoms, treatment, uncertainty, or disability. They should not make unverified medical promises.

7.24 Statements for Forgiveness

Forgiveness is personal and complex. It should not be required as a condition of spiritual worth or emotional recovery.

Possible stages include:

Not Ready

"I am not ready to forgive, and I acknowledge the reasons part of me remains protective."

Reducing Personal Burden

"I am willing to reduce the hold this anger has on my health and daily life."

Maintaining Boundaries

"Releasing some emotional burden does not require me to restore access or trust."

Considering Forgiveness

"I am open to exploring what forgiveness means to me without pressure."

Spiritual Request

"O Allah, guide me towards the response that is just, wise, and safe."

Forgiveness does not necessarily mean reconciliation, forgetting, excusing, withdrawing consequences, or returning to danger.

7.25 When Words Are Unnecessary

Some people become distracted by language. Others feel the emotion clearly but cannot form a sentence.

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Tapping can sometimes continue with:

- a single word;
- a bodily description;
- a sound;
- silence;
- an image held privately;
- a neutral phrase such as "this experience."

EFT materials acknowledge that tapping may sometimes proceed with very simple reminder phrases or without a formal set-up statement when the person is already emotionally connected with the issue.

Examples include:

"This pressure."

"That moment."

"Still frightened."

"I am here."

"O Allah, You know."

Silence should not be interpreted as resistance. The person may need privacy, time, or a less verbal method.

7.26 Common Statement Errors

Error 1: Being Too General

"Even though my life is difficult…"

Revision:

"Even though I feel helpless when I look at this month's unpaid bills…"

Error 2: Speaking for the Person

"You feel abandoned because your mother was emotionally unavailable."

Revision:

"What words would you use for what you felt?"

Error 3: Forcing Positivity

"I am completely happy and confident."

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Revision:

"I am open to becoming slightly steadier."

Error 4: Imposing Forgiveness

"I forgive him completely."

Revision:

"I am not ready to forgive, but I want to reduce the effect of this event on my daily life."

Error 5: Spiritual Blame

"My weak faith caused this anxiety."

Revision:

"I experience anxiety and spiritual self-criticism, and I ask for compassionate guidance."

Error 6: Medical Over-claim

"This tapping is removing the cause of my blood pressure."

Revision:

"I am addressing the emotional stress I notice while continuing medical monitoring and treatment."

Error 7: Controlling Another Person

"I choose that my family will respect me."

Revision:

"I choose to communicate my limits clearly and decide what I will do when they are not respected."

Error 8: Overloading the Statement

"Even though my husband criticized me, my mother-in-law rejected me, my children do not listen, I have financial problems, and nobody understands me…"

Revision:

Select one present target:

"Even though I feel hurt when I remember my husband's comment at breakfast this morning…"

7.27 Practitioner Questions for Developing Statements

A practitioner can use brief, open questions:

"What happened?"

"Which moment feels strongest?"

"What emotion fits best?"

"Where do you notice it?"

"What words are going through your mind?"

"What does this event seem to say about you?"

"Which part of the statement feels untrue?"

"Would you prefer acceptance, willingness, compassion, or neutral acknowledgement?"

"Would you like prayer included?"

"What spiritual words feel natural?"

"What remains within your control?"

"What would be one responsible next step?"

Questions should guide exploration rather than interrogate the person.

7.28 A Complete Statement-Building Example

Initial Problem

"I have no confidence."

Step 1: Identify the Situation

"I become anxious when I present my research."

Step 2: Identify a Specific Event

"During the last seminar, I forgot the answer to a question."

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Step 3: Identify the Emotion

"I felt ashamed."

Step 4: Identify the Body Response

"My face became hot and my throat tightened."

Step 5: Identify the Meaning

"I thought everyone had discovered that I was incompetent."

Step 6: Add Acceptance

"I acknowledge that this memory still affects me."

Step 7: Add Spiritual Intention

"I ask Allah for steadiness, humility, and clear expression."

Step 8: Add Responsible Action

"I can prepare carefully and accept that no speaker answers every question perfectly."

Final Set-Up Statement

"Even though I feel shame and tightness in my throat when I remember being unable to answer that question during the seminar, part of me believes everyone saw me as incompetent. I acknowledge how strongly that moment affected me. O Allah, grant me steadiness and clear expression. I can prepare responsibly without demanding perfection from myself."

Reminder Phrases

"That unanswered question."

"This shame in my face."

"They thought I was incompetent."

"This remaining fear of another question."

Later Integration Statements

"One unanswered question does not erase my knowledge."

"I can say that I need to check the evidence."

"I can remain professional without pretending to know everything."

"I will prepare responsibly and surrender the final outcome."

7.29 Statement Selection Guide

Present condition	Recommended language
Emotion is clear	Name the emotion directly
Emotion is unclear	Use "this discomfort" or bodily language
Self-acceptance feels false	Use acknowledgement or willingness
Distress is high	Shorten the statement and work at the edge
Person feels ashamed	Separate behavior from whole identity
Anger concerns injustice	Include dignity, boundaries, and responsible action
Forgiveness feels premature	State clearly that the person is not ready
Spirituality is supportive	Add personally chosen prayer or surrender
Spirituality is distressing	Acknowledge spiritual conflict without preaching
Person prefers secular language	Use values, meaning, compassion, and choice
Physical illness is involved	Address emotional burden without making medical claims
No words feel right	Use a short phrase, sensation, image, or silence

7.30 Professional Boundaries in Statement Development

The practitioner should not use suggestive statements to create memories or conclusions.

Avoid questions such as:

“Did your father’s rejection cause all your relationship problems?”

“Is this pain stored anger from childhood?”

“Did your soul choose this illness?”

These questions contain assumptions that the person may absorb even when they are unverified.

Use neutral inquiry:

“What comes to mind when you notice this sensation?”

“Does this experience connect with any memory for you?”

“What meaning do you give to what happened?”

“Is that interpretation certain, possible, or something you are still exploring?”

Ethical practice requires respect for autonomy, cultural belief, professional competence, and the distinction between the practitioner’s interpretation and the participant’s report.

7.31 Chapter Summary

Effective SEFT statements are specific, credible, emotionally accurate, culturally appropriate, and spiritually consensual.

The set-up statement provides a fuller description of the concern. The reminder phrase maintains attention during tapping. Integration and choice statements support a realistic next direction after the original experience has been acknowledged.

Statements should normally identify one particular event or aspect rather than an entire life problem. The person’s own language should be retained wherever possible. Emotions and thoughts can be described as experiences or parts of the self rather than as the person’s complete identity.

Acceptance does not mean approval, passivity, or forced forgiveness. When full acceptance feels false, the statement can use willingness, acknowledgement, curiosity, or self-compassion.

Spiritual language should express the person’s relationship with God, source of meaning, or values. It should not be used to blame the person, promise healing, demand surrender, or claim knowledge of divine intention.

The strongest SEFT statement is not the most positive statement. It is the statement that most honestly reflects where the person is now while opening a credible path towards emotional regulation, responsible action, and spiritual integrity.

Statement-Building Worksheet

Part A: Identify the Target

The specific event or situation is:

The exact moment that feels strongest is:

The emotion is:

The intensity is:
_____ /10

The bodily sensation is:

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The thought or belief is:

The feared meaning is:

Part B: Select Acceptance Language

Choose the phrase that feels most truthful:

☐ I accept that this is present.
☐ I acknowledge that this is present.
☐ I am willing to notice part of it.
☐ I am not ready to accept it, but I recognize its effect.
☐ I am willing to treat myself with less judgment.
☐ My own words:

Part C: Select Spiritual Language

☐ I would like explicit prayer.
☐ I prefer a quiet spiritual intention.
☐ I prefer values-based secular language.
☐ I do not want spiritual language included.

The spiritual or values-based words that fit are:

Part D: Write the Set-Up Statement

"Even though _____
when I think about _____,
I feel _____
in _____.
I acknowledge _____
and ask for _____."

Part E: Write the Reminder Phrase

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Part F: Write a Credible Bridging Statement

"I am not yet _____,
but I am willing to _____."

Part G: Identify Responsible Action

What is within my control?

What is not within my control?

My next responsible step is:

Chapter 8

Applying SEFT to Stress, Anxiety, Anger, and Emotional Overload

Stress, anxiety, anger, and emotional overload are related but distinct experiences. They may occur together, yet each requires a different emphasis during SEFT practice.

A person under stress may feel unable to meet current demands. An anxious person may anticipate danger or failure. An angry person may perceive injustice, disrespect, obstruction, or violation. Someone experiencing emotional overload may feel that several concerns have accumulated beyond their present capacity to organize or manage them.

SEFT should not be used merely to make uncomfortable feelings disappear. Emotions may contain important information. Anxiety may identify uncertainty or perceived danger. Anger may indicate a crossed boundary. Stress may reveal excessive demand, insufficient rest, or limited resources. Emotional overload may show that the person is trying to manage too many problems simultaneously.

The practical purpose of SEFT is to reduce emotional intensity sufficiently for the person to:

- understand the experience more clearly;
- distinguish present danger from anticipated danger;
- delay impulsive action;
- identify what is within personal control;
- seek appropriate support;
- choose a responsible next step.

The process may reduce subjective distress, but it does not remove the need to address the circumstances producing that distress.

8.1 Distinguishing the Four Experiences

Stress

Stress commonly arises when a person perceives that the demands of a situation exceed available time, energy, skills, resources, or support. It may be linked with work, caregiving, health, finances, family conflict, academic responsibilities, uncertainty, or major change.

The World Health Organization describes stress as a state of worry or mental tension caused by a difficult situation and notes that prolonged stress can affect daily functioning and well-being. WHO stress-management materials emphasize grounding, making room for difficult emotions, disengaging from unhelpful thoughts, acting according to values, and treating oneself with kindness.

Anxiety

Anxiety involves apprehension, worry, physiological activation, and anticipation of possible threat. It may be a normal response to uncertainty, but persistent anxiety can become clinically significant when it is severe, difficult to control, prolonged, or associated with considerable impairment.

Anxiety can appear as:

- repeated catastrophic thinking;
- restlessness;
- muscular tension;
- rapid heartbeat;
- stomach discomfort;
- difficulty concentrating;
- reassurance-seeking;
- avoidance;
- disturbed sleep;
- fear of losing control.

Anger

Anger may arise when a person experiences injustice, disrespect, frustration, betrayal, humiliation, obstruction, or threat. It can support self-protection and boundary-setting. The problem is not the existence of anger but the way it is interpreted, intensified, expressed, or acted upon.

Anger may become harmful when it leads to:

- verbal abuse;
- threats;
- physical aggression;
- revenge;
- destruction of property;
- unsafe driving;
- impulsive communication;
- violence towards oneself or another person.

Emotional Overload

Emotional overload occurs when several demands, emotions, decisions, memories, or responsibilities become active at the same time.

A person may say:

"I do not know where to begin."

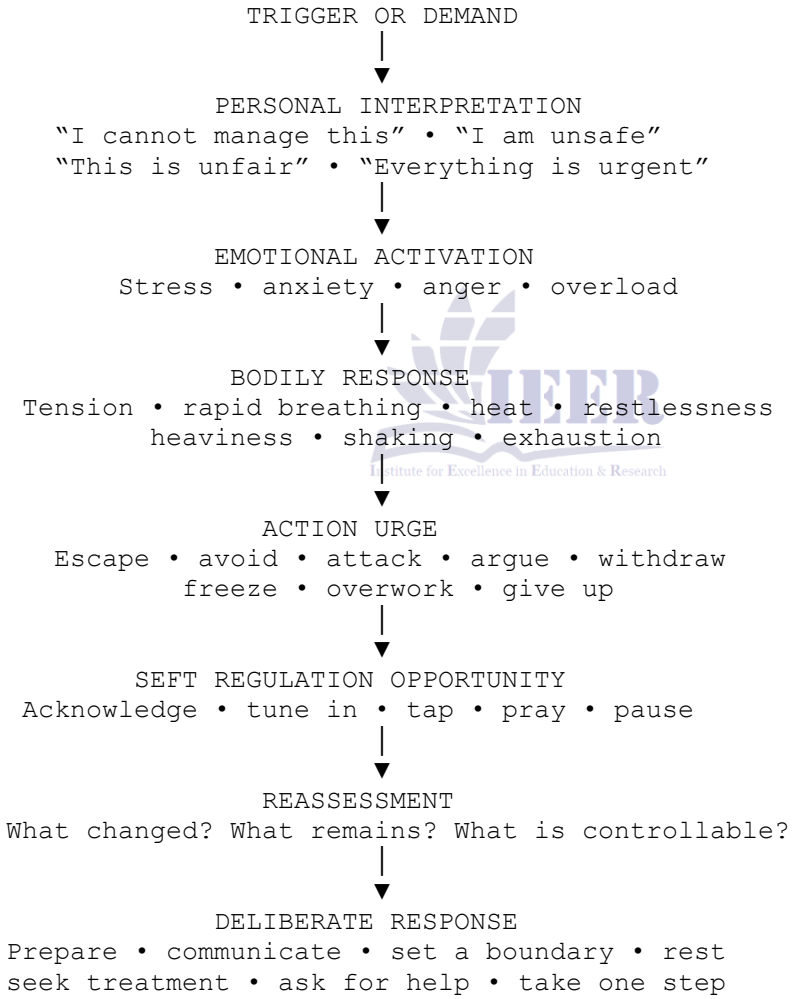
"Everything feels equally urgent."

"My mind cannot stop."

"I feel as if one more problem will break me."

In overload, the first goal is usually organization and stabilization, not detailed processing of every concern.

Figure 8: From Emotional Activation to Deliberate Action



SEFT is placed between emotional activation and action. It does not determine the correct decision, but it may help the person make that decision with less impulsivity.

8.2 Regulate First, Then Solve

When emotional activation is high, people often attempt to solve the entire external problem immediately. This can produce rushed decisions, hostile communication, avoidance, or mental exhaustion.

A more effective order is:

1. **Establish present safety.**
2. **Identify one active concern.**
3. **Regulate the immediate emotional response.**
4. **Reassess the problem.**
5. **Select one responsible action.**

For example, an employee who receives a critical email may feel an immediate urge to reply defensively. A brief SEFT round may reduce the intensity enough for the employee to read the message again, identify which part requires clarification, and prepare a professional response.

The purpose is not to make the criticism acceptable. It is to prevent the first wave of emotion from controlling the reply.

8.3 The Two-Scale Assessment

For stress and anxiety, a standard 0–10 distress rating may be sufficient.

For anger, two ratings are often more useful:

Emotional Intensity

"How strong is the anger from 0 to 10?"

Action Urge

"How strong is the urge to shout, threaten, strike, send the message, or take another immediate action?"

A person might report:

- anger intensity: 8;
- urge to send an insulting message: 6.

After tapping, anger may remain at 6 while the action urge falls to 2. This would be an important change because the person may now be able to delay the message.

A third optional rating is:

Functional Interference

"How much is this affecting your ability to work, sleep, communicate, or make decisions?"

Distress reduction is only one outcome. Improvement in functioning is often more meaningful.

8.4 A General Four-Question Preparation

Before applying SEFT, ask:

1. **What happened or is about to happen?**
2. **What emotion is strongest now?**
3. **Where is it felt in the body?**
4. **What action is needed after emotional regulation?**

For example:

Situation:
Three reports must be completed before Friday.

Emotion:
Stress and fear.

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Body:
Pressure behind the eyes and tension in the shoulders.

Thought:
"I will fail and everyone will blame me."

Action required:
Prioritize the reports, discuss the deadline, and ask for assistance.

This structure prevents the session from ending with emotional relief alone.

8.5 Applying SEFT to Immediate Stress

Immediate stress usually has an identifiable demand:

- an approaching deadline;
- an examination;
- an interview;
- a family responsibility;
- an unexpected expense;
- an important meeting;

- a difficult conversation;
- a medical appointment.

The target should be one specific part of the demand.

Instead of:

"I am stressed about my whole job."

Use:

"The pressure I feel when I look at the three unfinished reports."

Five-Minute Stress Protocol

Step 1: Orient to the Present

Notice the chair, room, feet, and current surroundings.

Step 2: Name the Immediate Demand

"I need to complete the report by tomorrow."

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Step 3: Rate the Stress

"Seven out of ten."

Step 4: Identify the Body Response

"Pressure behind my eyes and tightness in my shoulders."

Step 5: Form the Set-Up Statement

"Even though I feel overwhelmed when I think about completing this report by tomorrow, I acknowledge the pressure in my body. O Allah, help me become steady enough to identify the next responsible step."

Step 6: Tap Through the Short Sequence

Top of head:

"This deadline pressure."

Eyebrow:

"There seems to be too much to do."

Side of eye:

"I am afraid I will not finish."

Under eye:

"This pressure behind my eyes."

Under nose:

"My mind is trying to solve everything at once."

Chin:

"This stress in my shoulders."

Collarbone:

"I can pause and identify one section."

Under arm:

"I can ask what is genuinely urgent."

Top of head:

"I will take one responsible step at a time."

Step 7: Reassess

Ask:

- What is the stress rating now?
- Which task feels most urgent?
- Is the deadline fixed or negotiable?
- Is assistance available?
- What can be completed in the next thirty minutes?

The practical action may be more important than completing another tapping round.

8.6 Stress Caused by a Solvable Problem

Some stressors require direct problem-solving.

Examples include:

- an unclear schedule;
- an unpaid bill;
- an unfinished application;
- lack of information;
- an avoidable conflict;
- an unrealistic workload;
- absence of childcare;
- failure to ask for support.

In these situations, SEFT may help the person regulate avoidance or fear so that action becomes possible.

A set-up statement might be:

“Even though I feel anxious each time I open the unpaid bill; I acknowledge that avoiding it is increasing my stress. Help me become calm enough to review the amount and contact the organization.”

Tapping is not the final intervention. The telephone call, payment plan, budget discussion, or professional advice addresses the external problem.

8.7 Stress Caused by an Uncontrollable Situation

Other situations cannot be resolved immediately:

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- waiting for a test result;
- concern about another person’s decision;
- uncertainty about an application;
- separation from family;
- delayed legal proceedings;
- severe weather;
- political or social instability.

Here, SEFT may focus on uncertainty and the urge to control what cannot currently be controlled.

“Even though I do not know what the result will be, I acknowledge how difficult the waiting feels. I will take the actions available to me and place what I cannot control in Allah’s care.”

Surrender should not prevent preparation. The person may still gather information, attend appointments, seek advice, or prepare for several possible outcomes.

8.8 Chronic Stress and Burnout

A brief tapping exercise may reduce immediate emotional intensity, but chronic stress cannot always be managed through self-regulation alone.

Persistent stress may reflect:

- excessive workload;
- exploitation;
- inadequate staffing;
- caregiving without support;
- continuing financial hardship;
- workplace bullying;
- discrimination;
- chronic illness;
- unsafe housing;
- prolonged family conflict;
- insufficient rest.

In these circumstances, repeated tapping without structural change may unintentionally teach the person to tolerate conditions that require intervention.

A responsible SEFT session asks:

“What part of this stress belongs to my internal response?”

“What part is being maintained by an external condition?”

“What support, boundary, policy change, treatment, or practical resource is required?”

The Three-Column Stress Review

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Within my immediate control	I can influence but not control	Outside my control
The order of today’s tasks	Negotiating a deadline	Another person’s final decision
Asking for help	Workplace allocation	The result of an application
Taking a meal break	Family cooperation	Past events
Seeking medical advice	Team communication	Economic conditions
Turning off notifications	Organizational policy	Other people’s private opinions

SEFT can be used before acting on the first two columns and to reduce repeated struggle with the third.

8.9 Evidence Concerning EFT and Stress

Randomized studies have examined EFT for stress in several populations. A trial involving nurses caring for patients during the COVID-19 pandemic compared one brief online EFT session with no treatment and reported reductions in stress, anxiety, and burnout in the intervention group. The trial involved 72 nurses, which makes the findings relevant but not sufficient to establish effectiveness across occupations or forms of chronic stress.

A recently published systematic review and network meta-analysis has also examined Clinical EFT for psychological and physiological stress reduction. Its publication reflects a growing evidence base, but individual studies continue to differ in participants, intervention length, comparison conditions, outcome measures, and methodological quality.

SEFT-specific studies frequently involve local educational or healthcare samples, short interventions, nonrandomized designs, community projects, or small groups. Such findings can support further research but should not be treated as proof that SEFT is sufficient for occupational burnout, severe anxiety disorders, or complex psychosocial adversity.

8.10 A Burnout-Sensitive Statement

"Even though I feel exhausted and emotionally detached when I think about returning to work, I acknowledge that this may be more than a temporary bad day. Help me become clear enough to identify what support, rest, boundaries, or professional care I need."

The integration statement should not be:

"I can handle unlimited pressure."

A healthier statement is:

"My ability to endure does not remove the need for reasonable limits."

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8.11 Applying SEFT to Anxiety

SEFT may be used as a complementary emotional-regulation exercise for mild or moderate anxiety. It should not automatically be treated as a complete intervention for an anxiety disorder.

NICE recommends a stepped-care approach for generalized anxiety disorder. Assessment should consider distress, functional impairment, comorbid depression or anxiety, substance misuse, medical conditions, treatment history, and personal preference. For more impairing presentations, recommended options include evidence-based self-help, cognitive behavioral therapy, applied relaxation, medication, or specialist care according to severity and response.

SEFT may support but should not replace this assessment and treatment process.

8.12 Identify the Form of Anxiety

Anxiety statements become more effective when the type of fear is clear.

Anticipatory Anxiety

Fear about a future event:

"I am afraid I will forget my answers during the interview."

Social Anxiety

Fear of criticism, humiliation, or negative evaluation:

"They will notice that I am nervous and think I am incompetent."

Health Anxiety

Fear that symptoms indicate serious illness:

"This sensation must mean something dangerous."

Panic-Related Fear

Fear of bodily sensations or another panic episode:

"If my heart beats quickly, I will lose control."

Generalized Worry

Repeated worry across several areas:

"If I stop worrying, something will go wrong."

Trauma-Related Anxiety

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Fear linked with a traumatic event or reminder:

"The sound makes me feel that the event is happening again."

Each requires different assessment. Trauma-related anxiety, panic disorder, obsessive-compulsive symptoms, and severe health anxiety should not be approached as identical problems.

8.13 The Anxiety Cycle

Anxiety commonly develops through a repeating sequence:

1. a trigger appears;
2. the person predicts danger;
3. the body becomes activated;
4. bodily activation is interpreted as further evidence of danger;
5. the person avoids, escapes, checks, or seeks reassurance;
6. short-term relief reinforces the cycle.

SEFT can be placed between activation and avoidance:

"I notice the fear, tap, remain present, and then decide whether the situation is actually unsafe."

This does not mean that avoidance is always inappropriate. Leaving a genuinely dangerous situation is protective. The task is to distinguish reasonable safety behavior from anxiety-driven avoidance.

8.14 Anticipatory Anxiety Protocol

Step 1: Identify the Future Scene

"Entering the interview room."

Step 2: Identify the Worst Predicted Moment

"Being asked a question I cannot answer."

Step 3: Identify the Meaning

"They will believe I am unqualified."

Step 4: Identify the Body Response

"Tight throat and cold hands."

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Step 5: Rate the Anxiety

"Eight out of ten." 8/10

Step 6: Set-Up Statement

"Even though my throat tightens when I imagine being asked a question I cannot answer, and part of me believes this would prove that I am unqualified, I acknowledge this fear. O Allah, help me prepare carefully and respond with honesty and steadiness."

Step 7: Tapping Round

Top of head:

"This interview fear."

Eyebrow:

"The question I cannot answer."

Side of eye:

"They may think I am unqualified."

Under eye:

"This tightness in my throat."

Under nose:

"I am demanding perfect answers."

Chin:

"I am afraid of being judged."

Collarbone:

"I can pause before answering."

Under arm:

"I can say what I know and acknowledge what I need to check."

Top of head:

"I will prepare responsibly and surrender the outcome."

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Step 8: Behavioral Preparation

After tapping:

- practice likely questions;
- prepare a brief introduction;
- organize documents;
- rehearse a response to an unknown question;
- plan arrival time;
- obtain necessary information.

Tapping without preparation may become avoidance in another form.

8.15 Evidence Concerning EFT and Anxiety

A 2025 systematic review included parallel-group randomized trials of EFT for anxiety symptoms. Interventions varied widely from one to fifty-six sessions and comparison groups included no treatment, supportive interviews, CBT, breathing exercises, and progressive muscle relaxation. The review reported generally favorable findings but concluded that better-standardized, high-

quality trials and objective outcome measures are needed. It also found no significant difference from CBT in the available direct comparisons.

These findings support cautious investigation of EFT as a potentially useful complementary approach. They do not establish that EFT or SEFT should replace CBT, medication, applied relaxation, or specialist care for diagnosed anxiety disorders.

Research specifically labelled SEFT includes studies of examination anxiety, career anxiety, preoperative anxiety, and anxiety in medical populations. Much of this literature has been conducted in Indonesia and includes quasi-experimental, educational, or locally published studies. The results are encouraging in some samples, but the designs and protocols are not sufficiently uniform to support broad claims.

8.16 SEFT During a Panic-Like Episode

A person experiencing sudden intense fear may have rapid heartbeat, dizziness, sweating, trembling, breathlessness, chest discomfort, nausea, numbness, or fear of dying.

These symptoms may occur during panic, but similar symptoms can also be associated with medical conditions. A new, severe, or unusual episode especially chest pain, fainting, neurological symptoms, or significant breathing difficulty requires appropriate medical assessment.

NICE advises that a person presenting with a panic attack in an emergency setting should receive the investigations needed to exclude acute physical problems and should be referred for appropriate follow-up.

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When medical emergency has been excluded and the person recognizes the episode as a familiar anxiety response, a simple tapping phrase may be used:

“My body feels intensely activated, and I am here in the present.”

“I do not need to force the sensations away.”

“I can feel my feet and look around the room.”

“This wave can rise and fall.”

Avoid complex trauma exploration during an acute episode. The immediate goal is orientation, safety, and support.

8.17 Worry Versus Problem-Solving

Worry often feels productive because the mind is active. However, repeated mental rehearsal may continue without producing a decision.

Ask:

"Is there an action I can take now?"

If…… Yes:

- write it down;
- schedule it;
- contact the relevant person;
- gather information;
- complete one step.

If……. No:

- acknowledge uncertainty;
- regulate the present response;
- return attention to the current activity.

A SEFT statement might be:

"Even though my mind keeps repeating this question because it wants certainty, no further action is available tonight. I acknowledge the uncertainty and allow myself to return to the present evening."

8.18 Applying SEFT to Anger

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Anger should not be treated as an unwanted emotion that must be eliminated. It may indicate:

- violation of dignity;
- broken trust;
- injustice;
- blocked goals;
- threat;
- helplessness;
- humiliation;
- unresolved grief;
- unmet needs;
- accumulated stress.

The first task is to distinguish:

1. the anger;
2. the underlying meaning;
3. the action urge;
4. the responsible response.

Example

Trigger:
A colleague interrupted repeatedly.

Anger:
8 out of 10. “8/10”

Underlying meaning:
“My contribution is not respected.”

Action urge:
Send an insulting message.

Responsible response:
Wait, review what happened, and request a direct conversation.

8.19 Anger Safety Check

Before tapping, ask:

- Is anyone in immediate danger?
- Is the person holding a weapon?
- Has violence already occurred?
- Is the person intoxicated?
- Is there a plan to harm someone?
- Is a child or vulnerable adult at risk?
- Can the person move away from the conflict?
- Can another responsible person provide support?

Where immediate violence is possible, the priority is separation, safeguarding, crisis support, and emergency intervention not detailed emotional processing.

SEFT should not be used to delay protection or convince an abused person to remain calm within a dangerous situation.

8.20 Anger Regulation Protocol

Step 1: Move Away from Immediate Action

Do not send the message, drive towards the person, continue the argument, or make a major decision while highly activated.

Step 2: Rate Both Anger and Action Urge

“Anger: 9.”

“Urge to send the message: 8.”

Step 3: Name the Violation

"I was excluded from a decision that directly affects my work."

Step 4: Identify the Body Response

"Heat in my face and pressure in my hands."

Step 5: Set-Up Statement

"Even though I feel intense anger about being excluded from this decision, I acknowledge that I feel disrespected. O Allah, help me protect my dignity and communicate firmly without becoming unjust or destructive."

Step 6: Tapping Round

Top of head:

"This intense anger."

Eyebrow:

"I was excluded."

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Side of eye:

"They acted as if my contribution did not matter."

Under eye:

"This heat in my face."

Under nose:

"Part of me wants to attack."

Chin:

"I want them to understand how angry I am."

Collarbone:

"The anger is telling me that a boundary was crossed."

Under arm:

"I do not need to obey every angry impulse."

Top of head:

"I can choose a firm and responsible response."

Step 7: Reassess

"Anger: 6."

"Urge to send the message: 3."

Step 8: Choose Action

Possible actions include:

- drafting but not sending a response;
- documenting the incident;
- requesting clarification;
- arranging a meeting;
- consulting a supervisor;
- making a formal complaint;
- establishing a boundary;
- deciding that no immediate response is useful.

The correct action depends on the context, not on the tapping script.

8.21 Working Beneath Anger

Anger sometimes protects a more vulnerable emotion.

After one round, ask:

"If the anger became slightly quieter, what might be underneath it?"

Possible responses include:

- hurt;
- fear;
- shame;
- rejection;
- grief;
- helplessness;
- disappointment.

A person may discover:

"I am angry because nobody defended me."

The next set-up can address the underlying hurt:

"Even though I remain angry, I now recognize how abandoned I felt when everyone stayed silent. I acknowledge that hurt and ask for wisdom in deciding whom I can trust."

The practitioner should not assume that every anger response conceals sadness or fear. The person identifies what is present.

8.22 Anger and Injustice

Spiritual language can be misused to silence legitimate anger.

Statements such as:

"You must surrender."

"A good believer should remain quiet."

"Forgive immediately."

may pressure the person to tolerate mistreatment.

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A more ethical statement is:

"O Allah, help me seek justice without becoming unjust."

Or:

"I can regulate my anger while maintaining a clear boundary."

Emotional calm does not require reconciliation, renewed trust, or withdrawal of legitimate consequences.

8.23 Evidence Concerning EFT and Anger

Small controlled studies have examined EFT for anger-related outcomes. In a pilot randomized trial involving people with *hwabyung*, both EFT and progressive muscle relaxation improved several outcomes, while between-group differences were limited. Another four-week study reported broader improvements in anger and anxiety measures for EFT than progressive muscle relaxation, but the samples were small and the cultural and diagnostic context was specific.

SEFT-specific evidence for anger remains limited. A 2022 qualitative study of students concluded that SEFT alone was considered ineffective for reducing students' anger and suggested that it

functioned more appropriately as a supportive element within broader educational work. This finding is important because not all SEFT studies report favorable conclusions.

The evidence therefore supports cautious use as an adjunctive regulation exercise, not the claim that SEFT is a complete or universally effective anger treatment.

8.24 Anger That Requires Specialist Intervention

Professional support is indicated when anger involves:

- repeated violence;
- threats;
- coercive control;
- stalking;
- weapon access;
- cruelty towards children, partners, animals, or vulnerable people;
- serious property destruction;
- intoxication-related aggression;
- legal consequences;
- inability to remember episodes;
- suicidal or homicidal thoughts;
- manic, psychotic, or severe dissociative symptoms.

A tapping exercise is not an adequate safeguarding plan.

8.25 Applying SEFT to Emotional Overload

Emotional overload differs from a single specific emotion. Several concerns may compete for attention:

“My health, work, children, finances, and publication deadlines are all in my mind.”

The person may be unable to choose one target because every concern feels urgent.

In this situation, begin with the overload itself.

Overload Set-Up

“Even though everything feels active at once and I do not know where to begin, I acknowledge that my mind is overloaded. O Allah, help me become steady enough to identify only the next necessary step.”

Overload Tapping Round

Top of head:

"Everything feels urgent."

Eyebrow:

"Too many thoughts."

Side of eye:

"I do not know where to begin."

Under eye:

"This pressure in my head."

Under nose:

"I am trying to solve the whole week right now."

Chin:

"I feel emotionally crowded."

Collarbone:

"I only need to choose the next step."

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Under arm:

"One problem does not need to contain every other problem."

Top of head:

"I can organize what requires attention first."

After tapping, write every concern on paper rather than holding it mentally.

8.26 The Overload Triage

Divide concerns into four categories.

Category	Meaning	Action
Immediate and important	Requires action today	Select the first concrete step
Important but not immediate	Needs scheduling	Place it in the calendar or task plan
Waiting on another person	Cannot be completed now	Record follow-up date

Not presently actionable	Outside current control	Return attention to present priorities

This process converts an emotional mass into separate decisions.

8.27 The "Only This Moment" Method

When overload remains high, reduce the time frame.

Instead of:

"How will I manage this month?"

ask:

"What requires attention in the next ten minutes?"

A brief statement is:

"Even though my mind is trying to live the whole month at once, I am here in this hour."

Possible immediate actions include:

- drinking water;
- taking prescribed medication;
- making one telephone call;
- sending one necessary email;
- preparing one meal;
- completing one paragraph;
- resting for fifteen minutes;
- asking someone for help.

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The method does not deny long-term responsibilities. It restores enough organization to begin.

8.28 When Rest Is the Responsible Action

People sometimes use tapping to push through exhaustion:

"I will tap until I can work longer."

This may be inappropriate when the body requires sleep, food, medical care, reduced workload, or recovery.

A responsible statement may be:

"Even though part of me feels guilty about stopping, exhaustion is information. I can rest now and review the task when I have greater capacity."

SEFT should not become a tool for increasing self-exploitation.

8.29 Spiritual Integration Across the Four States

Spiritual language should be matched to the emotional task.

During Stress

"Help me distinguish what is urgent from what can wait."

During Anxiety

"Grant me courage to face uncertainty without imagining that every feared outcome is certain."

During Anger

"Help me protect what is right without becoming harmful in my response."

During Overload

"Guide me towards the next necessary step and help me release what cannot be managed today."

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During Helplessness

"Show me where action is possible and where surrender is necessary."

During Uncertainty

"I will prepare responsibly and entrust the final outcome to You."

Spiritual surrender should occur after not instead of identifying practical responsibility.

8.30 The Difference Between Surrender and Avoidance

Surrender	Avoidance
Acknowledges reality	Refuses to examine reality
Takes available action	Delays necessary action
Accepts limits of control	Uses spirituality to escape responsibility
Seeks appropriate help	Rejects treatment or advice
Allows uncertainty	Demands emotional numbness
Maintains ethical boundaries	Tolerates preventable harm
Entrusts the outcome	Abandons the process

A person may say:

“I surrender this result to Allah.”

The practitioner can ask:

“What remains within your responsibility before the result is known?”

This preserves the balance between faith and action.

8.31 Brief Scripts for Common Situations

Academic Stress

“Even though I feel overwhelmed when I look at the examination material, I do not need to study everything at once. I can select one topic and work for the next thirty minutes.”

Workplace Anxiety

“Even though I fear the meeting, I can prepare my main points and ask for clarification when needed.”

Family Anger

“Even though I feel angry that my opinion was dismissed, I can communicate my boundary without insulting anyone.”

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Caregiver Overload

“Even though I feel guilty when I need rest, caring for another person does not remove my own physical limits.”

Publication Anxiety

“Even though I fear rejection, I can review the manuscript carefully, submit it responsibly, and recognize that the editorial decision is not fully within my control.”

Financial Stress

“Even though I feel frightened when I look at the expenses, I am willing to examine the actual figures and seek practical advice.”

Health-Related Fear

“Even though this symptom frightens me, I will obtain appropriate medical assessment and regulate the anxiety while I wait.”

Anger After Humiliation

"Even though I feel humiliated and angry, I can allow the first emotional wave to settle before deciding how to respond."

8.32 Monitoring Change

After each round, record more than the distress number.

Ask:

Emotional Change

- Is the emotion less intense?
- Has another emotion appeared?
- Does the emotion feel more understandable?

Bodily Change

- Has the tension moved?
- Is breathing easier?
- Is the body calmer, unchanged, or more activated?

Cognitive Change

- Does the feared thought still feel completely true?
- Is another interpretation possible?
- Is the problem more specific?

Behavioral Change

- Is the urge to avoid, attack, or withdraw different?
- Can one responsible action now be identified?
- Is communication possible?

Spiritual Change

- Does prayer feel more authentic?
- Has guilt reduced or increased?
- Is surrender being confused with helplessness?
- Does the person need trust spiritual guidance?

A lower distress score is useful, but it is not the only indicator of progress.

8.33 When to Stop a Round

Stop or pause when:

- distress rises rapidly;
- the person becomes disoriented;
- panic intensifies;
- a severe trauma memory emerges;
- the person asks to stop;
- physical discomfort develops;
- the exercise becomes mechanical;
- the person is exhausted;
- no further productive change is occurring;
- practical action is now more appropriate.

The absence of a zero rating does not mean the round has failed.

8.34 When to Seek Professional Support

Professional assessment should be considered when stress, anxiety, anger, or overload:

- persists for several weeks;
- causes marked impairment;
- prevents sleep, eating, work, or self-care;
- leads to repeated avoidance;
- is associated with depression;
- involves substance misuse;
- follows trauma;
- includes panic attacks;
- produces violent behavior;
- involves obsessive or compulsive patterns;
- is connected with severe medical symptoms;
- includes thoughts of self-harm or harm to others.

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NICE's stepped-care approach emphasizes assessment of severity, impairment, comorbidity, physical conditions, substance misuse, treatment response, and personal preference rather than relying solely on a symptom score.

8.35 Chapter Summary

Stress, anxiety, anger, and emotional overload require different SEFT targets.

Stress work should distinguish emotional activation from the practical demand that must be addressed. Anxiety work should identify the feared future event, bodily response, avoidance pattern, and realistic preparation. Anger work should separate the emotion from the action urge and support firm but responsible behavior. Overload work should begin with stabilization and organization rather than attempting to process every problem simultaneously.

Research on EFT for anxiety and stress is encouraging but varied. Trials differ considerably in intervention length, populations, comparison groups, and outcome measures. SEFT-specific studies are generally smaller and methodologically less consistent. Some report improvement, while at least one qualitative study concluded that SEFT alone was insufficient for student anger. These findings require balanced interpretation rather than promotional claims.

SEFT should be used to increase clarity and choice. It should not be used to tolerate unsafe conditions, suppress legitimate anger, replace evidence-based anxiety treatment, avoid practical responsibility, or push the body beyond reasonable limits.

The final question after a tapping round is not only:

“Do I feel better?”

It is also:

“What is the wisest, safest, and most responsible action available to me now?”

Practice Worksheet

Part A: Identify the Present State

My main experience is:

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☐ Stress
☐ Anxiety
☐ Anger
☐ Emotional overload
☐ A combination

The specific trigger is:

The strongest emotion is:

I notice it in my body as:

The main thought is:

Distress intensity:
_____ /10

Action urge, if relevant:
_____ /10

Functional interference:
_____ /10

Part B: Separate the Problem

What is within my immediate control?

What can I influence but not control?

What is outside my control?

Part C: Set-Up Statement

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"Even though _____
when I think about _____,
I acknowledge _____
and ask for _____."

Part D: Reminder Phrases

Top of head:

Eyebrow:

Side of eye:

Under eye:

Under nose:

Chin:

Collarbone:

Under arm:

Part E: Reassessment

Distress after tapping:
_____ /10

Action urge after tapping:
_____ /10

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What changed?

What remains?

The next responsible step is:

Support I may need:

Chapter 9

Grief, Rejection, Shame, and Relationship Pain

Some of the most enduring emotional pain develops through attachment and loss. A person may grieve someone who has died, but grief can also follow divorce, separation, infertility, retirement, migration, loss of employment, disability, serious illness, professional rejection, or the collapse of an expected future. The circumstances differ, yet each may involve the loss of a person, role, identity, relationship, opportunity, or source of meaning.

Rejection and relationship injuries may carry a similar emotional complexity. A person may feel sadness because a relationship has changed, anger because the treatment was unfair, humiliation because the rejection was public, shame because the event has been interpreted as evidence of personal defectiveness, or guilt because the person regrets their own behavior.

SEFT may help an individual approach one manageable aspect of such pain while remaining emotionally and spiritually grounded. It should not be used to erase attachment, impose forgiveness, secure reconciliation, or persuade someone to remain in an unsafe relationship.

The central goals are more modest and clinically responsible:

- to acknowledge the reality of the loss or injury;
- to reduce emotional, overwhelm;
- to separate the event from global self-condemnation;
- to identify unfinished practical or relational matters;
- to preserve dignity and personal safety;
- to support gradual adaptation;
- to recognize when specialist treatment is required.

9.1 Understanding Loss

Loss changes more than external circumstances. It may affect routine, identity, belonging, financial security, family roles, future expectations, spiritual meaning, and the person's understanding of themselves.

Following the death of a spouse, for example, the surviving person may lose:

- emotional companionship;
- practical assistance;
- shared parenting;
- financial support;
- social identity as part of a couple;
- daily rituals;
- plans for later life;
- a witness to personal history.

A professional loss may similarly involve more than income. It may affect status, purpose, social contact, independence, confidence, and expectations about the future.

This is why statements such as "You need to move on" are usually unhelpful. They reduce a multidimensional loss to a demand for emotional closure.

A more respectful question is:

"What, specifically, has been lost through this experience?"

The answer may reveal several areas requiring different forms of support.

9.2 Grief Does Not Follow One Fixed Pattern

Grief can include sadness, longing, disbelief, anger, guilt, relief, numbness, fear, loneliness, confusion, gratitude, or moments of ordinary enjoyment. Different emotions may coexist.

A person may laugh during a family gathering and cry later that evening. Another may initially feel numb and experience stronger grief months later. A person who cared for someone through a long illness may experience both sorrow and relief that suffering has ended.

No single emotional sequence describes every bereaved person. Grief may become more intense around anniversaries, religious occasions, family events, familiar places, particular songs, medical appointments, or unexpected reminders.

A tapping practitioner should therefore avoid statements such as:

"You are still in the denial stage."

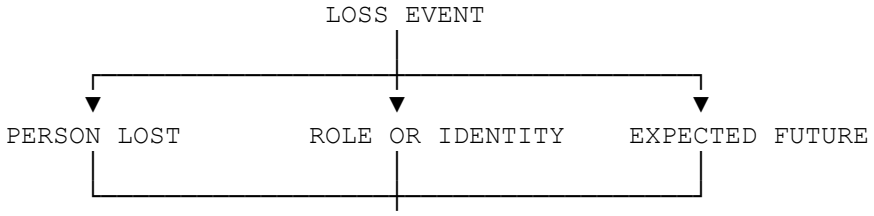
"You should have reached acceptance by now."

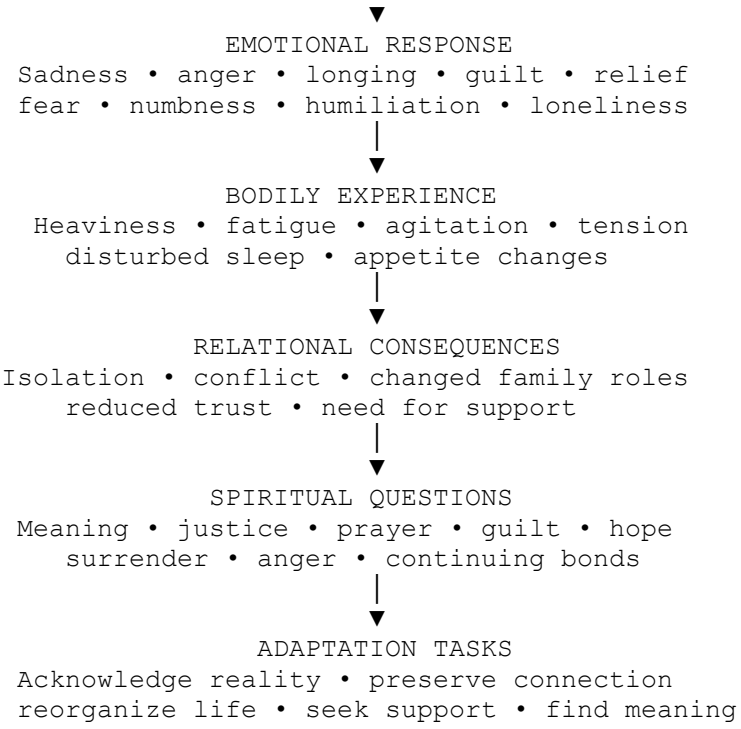
"Your grief is blocked."

These conclusions may pathologies normal variation and place an artificial timetable on adaptation.

Figure 9

Dimensions of Grief and Relationship Loss





Note. These dimensions interact. Adaptation does not require forgetting the person or denying the importance of the relationship.

9.3 Natural Grief and Prolonged Grief Disorder

Most grief is painful without being a mental disorder. The intensity may fluctuate, but many people gradually regain the ability to participate in relationships, responsibilities, and meaningful activities.

A smaller group develops severe, persistent grief associated with substantial impairment. The DSM-5-TR diagnosis of prolonged grief disorder applies to bereavement following the death of a close person. For adults, at least 12 months must have passed since the death; for children and adolescents, at least six months. Symptoms must be persistent, clinically significant, impair functioning, and exceed what would be expected within the person's social, cultural, and religious context.

Possible features include:

- intense longing or preoccupation with the deceased;
- disbelief concerning the death;
- avoidance of reminders;
- severe emotional pain;
- identity disruption;
- emotional numbness;
- difficulty reintegrating into life;

- intense loneliness;
- a sense that life is meaningless without the deceased.

The time criterion alone does not establish a diagnosis. A person may continue to miss someone deeply after many years without having prolonged grief disorder. Assessment must consider severity, functioning, cultural and religious mourning practices, other mental-health conditions, and the person's individual circumstances.

Evidence-based grief treatments commonly include cognitive-behavioral and grief-focused methods that help people acknowledge the reality of the death, reduce disabling avoidance, maintain a meaningful connection with the deceased, and re-engage with life.

SEFT should not be presented as a replacement for these treatments.

9.4 The Appropriate Role of SEFT in Grief

SEFT may be used as a complementary regulation exercise for:

- a particular wave of sadness;
- anxiety before a funeral or memorial event;
- guilt about one specific interaction;
- distress associated with a hospital memory;
- difficulty looking at a photograph;
- anger about circumstances surrounding the death;
- bodily tension during a grief trigger;
- fear of returning to a meaningful place;
- spiritual confusion connected with the loss.

The target should not be:

"My entire grief."

A more manageable focus is:

"The tightness in my chest when I see his empty chair."

Or:

"The guilt I feel when I remember missing her final telephone call."

The aim is not to reduce love or force emotional detachment. It is to help the person remain connected with the memory without becoming entirely overwhelmed.

9.5 What SEFT Should Not Promise in Bereavement

SEFT should not be described as a method that:

- completes grief in a fixed number of sessions;
- erases the emotional bond;
- removes every painful memory;
- guarantees spiritual acceptance;
- enables contact with the deceased;
- identifies a divine reason for the death;
- proves that grief is caused by blocked energy;
- replaces grief-focused psychotherapy;
- removes the need for social or family support.

Statements such as the following are inappropriate:

"Your grief remains because you have not surrendered."

"The soul has chosen this event for your spiritual development."

"Tapping will release the deceased person from your energy."

These claims cannot be established by the practitioner and may intensify guilt or spiritual confusion.

A more responsible position is:

"We can work with the distress connected with this particular moment while respecting the importance of the relationship and your own beliefs about the loss."

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9.6 A Loss-Sensitive SEFT Protocol

This protocol is intended for a manageable grief trigger. It is not designed for a person who is actively suicidal, severely dissociated, unable to function, or overwhelmed by traumatic circumstances surrounding the death.

Step 1: Identify One Grief Moment

Examples include:

- seeing an empty chair;
- entering the person's room;
- hearing a familiar song;
- remembering the hospital;
- attending a family event alone;
- looking at an unread message;
- thinking about an anniversary.

Step 2: Identify the Active Emotion

The emotion may be:

- sadness;
- longing;
- guilt;
- anger;
- fear;
- loneliness;
- relief followed by shame;
- spiritual confusion.

Step 3: Identify the Bodily Experience

"A heavy pressure in the center of my chest."

Step 4: Rate the Intensity

"Seven out of ten." "7/10"

Step 5: Form the Set-Up Statement

"Even though seeing the empty chair brings a heavy wave of grief, I acknowledge how deeply I miss him. O Allah, help me remain present with this moment and carry this loss with patience."

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Step 6: Tap Gently

Top of head:

"This wave of grief."

Eyebrow:

"The empty chair."

Side of eye:

"I still expect him to be there."

Under eye:

"This heaviness in my chest."

Under nose:

"I miss the ordinary moments."

Chin:

"Part of me cannot believe he is gone."

Collarbone:

"I do not need to erase my love."

Under arm:

"I can allow this wave to pass through gradually."

Top of head:

"O Allah, help me carry what I cannot change."

Step 7: Pause and Reassess

Ask:

- Has the intensity changed?
- Is the sadness now more specific?
- Has guilt, anger, or another memory emerged?
- Does the person need to stop?
- Is practical or social support needed?

A grief round does not need to reach zero. A decrease from overwhelming to tolerable may be sufficient.

9.7 Continuing Bonds

Adaptation does not require forgetting the deceased. Many people maintain a continuing internal bond through memories, values, prayer, family stories, charitable action, photographs, rituals, or carrying forward something learned from the person.

A SEFT statement may acknowledge this relationship:

"Even though I feel pain when I remember her, I do not need to remove her importance from my life. I can carry the relationship in a different form."

For a Muslim participant:

"O Allah, have mercy on the person I have lost. Help me honor the relationship through prayer, gratitude, and responsible living."

The statement should support connection without denying the reality of death.

9.8 Guilt After Bereavement

Bereavement guilt may concern:

- words said or left unsaid;
- absence at the time of death;
- treatment decisions;
- feeling relief;
- surviving;
- enjoying life again;
- unfinished conflict;
- believing that more should have been done.

Guilt should be examined carefully.

Ask:

1. What does the person believe they did or failed to do?
2. What information was available at that time?
3. What was realistically within their control?
4. Is there actual responsibility, imagined responsibility, or both?
5. Is any meaningful reparative action still possible?

A set-up statement might be:

“Even though I blame myself for not being present at the hospital, I acknowledge the pain of that absence. I am willing to examine what was genuinely within my control rather than punish myself without limit.”

If real responsibility exists:

“Even though I regret my behavior, I am willing to face it honestly, ask forgiveness, and identify how I can live differently.”

Tapping should not be used to avoid moral responsibility. It may help the person face responsibility without collapsing into permanent self-condemnation.

9.9 Anticipatory Grief

Anticipatory grief may arise before an expected death or major loss. It can include fear, sadness, helplessness, uncertainty, guilt, and repeated mental rehearsal of the future.

A person caring for someone with a life-limiting illness may simultaneously:

- hope for improvement;
- fear deterioration;
- grieve changes that have already occurred;
- feel exhausted;
- experience guilt about needing rest;
- worry about practical responsibilities;
- avoid discussing the future.

A SEFT target might be:

"The fear I feel when I imagine the next medical appointment."

A possible statement is:

"Even though I am afraid of what the physician may say, I acknowledge that I am carrying grief and uncertainty before the outcome is known. Help me remain present, ask the necessary questions, and take one day at a time."

A 2025 meta-analysis of 10 randomized trials involving people with cancer reported reductions in anxiety, depression, and some aspects of anticipatory grief following EFT, but the authors also identified limitations and called for standardized outcomes. A later 2025 randomized trial involving 58 people with cancer reported benefits from a four-week EFT intervention plus routine care compared with routine care alone. These findings concern anticipatory grief in medical populations; they do not establish EFT or SEFT as a general treatment for bereavement after death.

The direct evidence for SEFT in grief remains insufficient for it to be presented as an established grief therapy.

9.10 Grief After Relationship Loss

The end of a marriage, engagement, friendship, or other close relationship may involve grief even when both people remain alive.

The loss may include:

- daily contact;
- emotional intimacy;
- family connections;
- shared plans;
- social identity;
- housing or financial stability;
- trust;
- an expected future.

Relationship grief can be complicated by ambiguity. The person may continue to see the former partner, receive occasional messages, share parenting responsibilities, or hope for reconciliation. The relationship may have ended formally while remaining emotionally active.

A useful SEFT target is one particular trigger:

“The distress I feel when I see that they have read my message but not replied.”

Or:

“The emptiness I feel when I enter the house after the separation.”

The aim is not to decide through tapping whether the relationship should resume. Emotional regulation should precede but not replace careful evaluation of the relationship.

9.11 Understanding Rejection

Rejection communicates, or appears to communicate, that a person is not wanted, valued, selected, included, trusted, or accepted within a particular relationship or group.

It may occur through:

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- exclusion;
- dismissal;
- criticism;
- silence;
- abandonment;
- betrayal;
- professional rejection;
- romantic separation;
- social-media interactions;
- unfavorable comparison;
- denial of promotion;
- family scapegoating.

Research indicates that rejection does not create one uniform emotion. A 2026 investigation found that different interpretations were associated with different reactions. Perceived unfairness was linked particularly with anger, while internalizing another person’s devaluation was associated with shame. Humiliation contained elements of both unfairness and internalized devaluation and was associated with confrontation as well as avoidance.

This distinction is useful in SEFT.

A person who thinks:

“They treated me unfairly”

may feel anger.

A person who concludes:

“Their rejection proves that I am defective”

may feel shame.

A person who experiences both may feel humiliated.

The wording should match the actual emotional pathway.

9.12 Event Versus Identity

Rejection is an event. Shame converts the event into an identity judgment.

Event

“My application was rejected.”

Interpretation

“They did not consider me suitable for this position.”

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Global Identity Conclusion

“I am professionally worthless.”

The first two statements describe an outcome and a possible interpretation. The third turns one decision into a complete judgment of the self.

SEFT may help separate these levels:

“Even though the rejection letter activated the belief that I am professionally worthless, I recognize that this is a painful conclusion formed in response to one decision.”

This statement does not deny disappointment. It prevents the outcome from becoming the only evidence used to evaluate the person’s career or worth.

9.13 SEFT Protocol for Rejection

Target

A manuscript, job application, proposal, or relationship request has been rejected.

Initial Emotion

Humiliation and sadness.

Bodily Response

Heat in the face and heaviness in the chest.

Initial Rating

Eight out of ten.

Set-Up Statement

“Even though this rejection makes me feel humiliated, and part of me believes it proves that I am not good enough, I acknowledge the hurt. O Allah, help me distinguish this outcome from my complete worth and guide me towards the next responsible step.”

Tapping Round

Top of head:

“This painful rejection.”

Eyebrow:

“I was not selected.”

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Side of eye:

“Part of me feels exposed.”

Under eye:

“This heat in my face.”

Under nose:

“I am turning one decision into a judgment of my whole self.”

Chin:

“I feel hurt and disappointed.”

Collarbone:

“I can examine the feedback without humiliating myself.”

Under arm:

"I can decide whether to revise, respond, appeal, or move forward."

Top of head:

"I will use what is useful and release what is outside my control."

Reassessment

Ask:

- Is the pain about the lost opportunity, the manner of rejection, or both?
- Does the person have reliable feedback?
- Was the process fair?
- Is an appeal or clarification appropriate?
- Has an older rejection memory become active?
- What action is available now?

9.14 Repeated Rejection and Older Wounds

A present rejection may activate an earlier experience:

"This feels exactly like being ignored by my family."

"It reminds me of not being selected at school."

"I feel like the child nobody wanted."

The earlier memory should not automatically be treated in the same session. First determine whether the person remains stable and whether the practitioner is qualified to work with the history involved.

A bridging statement may be:

"Even though this present rejection has activated an older feeling of being unwanted, I do not need to enter the whole earlier experience today. I can acknowledge the connection and work only with what feels manageable."

The current event and the older memory may require separate targets.

9.15 Shame and Guilt

Shame and guilt frequently occur together, but they are not identical.

Guilt

Guilt generally concerns an action:

"I did something that conflicts with my values."

It may motivate apology, repair, changed behavior, or restitution.

Shame

Shame concerns the self:

"What I did proves that I am fundamentally bad, defective, inferior, or unworthy."

Shame often produces concealment, withdrawal, defensiveness, emotional collapse, or attack against others.

A recent scoping review found that psychosocial interventions can reduce internalized shame, particularly when they include psychoeducation, emotional expression, experiential work, and social support. However, the included evidence was methodologically weak to moderate, and active interventions were not consistently superior to other credible treatments.

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Compassion-focused approaches have also shown promise for reducing self-criticism and some forms of shame, although study quality and outcomes vary.

SEFT can incorporate compassionate language, but it should not be presented as a complete shame treatment based on current evidence.

9.16 Shame-Sensitive Language

A shame-sensitive statement should:

- describe the event or behavior;
- acknowledge the emotional response;
- avoid defining the whole person by one experience;
- preserve accountability;
- introduce compassion gradually;
- identify possible repair.

Example

"Even though I feel ashamed about what I said, and part of me wants to hide from everyone, I acknowledge that I behaved in a way I regret. I can take responsibility without treating myself as permanently worthless."

Spiritual Version

"O Allah, I regret my behavior and ask for forgiveness and guidance. Help me make amends where possible and prevent shame from turning into hopelessness."

The statement should not offer easy absolution:

"I have tapped, so the matter is finished."

Nor should it demand endless punishment:

"Because I made this mistake, I do not deserve peace."

9.17 A Shame-Regulation Protocol

Step 1: Describe the Event Factually

"I gave incorrect information during the meeting."

Step 2: Identify the Shame Conclusion

"Everyone now knows I am incompetent."

Step 3: Identify Actual Responsibility

"I should correct the information."

Step 4: Rate the Shame

"Nine out of ten."

Step 5: Form the Set-Up

"Even though I feel intense shame about giving incorrect information, I acknowledge that I made a mistake. I am willing to correct it without declaring that one error defines my entire professional identity."

Step 6: Tap

Top of head:

"This intense shame."

Eyebrow:

"I gave the wrong information."

Side of eye:

"I imagine everyone judging me."

Under eye:

"I want to disappear."

Under nose:

"Part of me believes this mistake defines me."

Chin:

"I need to take responsibility."

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Collarbone:

"Responsibility does not require self-destruction."

Under arm:

"I can correct the information clearly."

Top of head:

"I can learn, repair, and continue."

The practical next step may be sending a correction, apologizing, or seeking supervision.

9.18 Relationship Injuries

Relationship pain may arise from:

- betrayal;
- infidelity;

- emotional neglect;
- repeated criticism;
- secrecy;
- broken promises;
- public humiliation;
- emotional withdrawal;
- family interference;
- lack of protection;
- financial control;
- abandonment;
- coercion or violence.

These experiences should not be collapsed into the vague phrase:

“Relationship stress.”

A useful SEFT target identifies the precise injury:

“The moment I discovered the message.”

“His silence when his family insulted me.”

“The sentence she used when ending the relationship.”

“The fear that I cannot trust my own judgment.”

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Relationship injuries may affect several forms of trust:

1. trust in the other person;
2. trust in the relationship;
3. trust in one’s perceptions;
4. trust in one’s ability to make decisions;
5. spiritual trust or meaning.

Each may require separate work.

9.19 A Betrayal-Focused SEFT Round

Target

The image of discovering concealed communication.

Set-Up

"Even though remembering that message brings shock, anger, and pain, I acknowledge that my trust was injured. O Allah, help me remain grounded enough to understand what happened and decide what protects my dignity and well-being."

Tapping Round

Top of head:

"The shock of discovering it."

Eyebrow:

"I did not expect this."

Side of eye:

"I question what was real."

Under eye:

"This pain in my chest."

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Under nose:

"Part of me wants an immediate answer."

Chin:

"Part of me wants to withdraw completely."

Collarbone:

"I do not have to decide everything in this emotional state."

Under arm:

"I can gather information and establish boundaries."

Top of head:

"I ask for clarity, dignity, and wise action."

Reduced distress does not prove that trust has been restored. Trust repair requires behavior over time, accountability, honesty, consistency, and voluntary participation from the people involved.

9.20 Emotional Relief Is Not Reconciliation

A person may experience less anger after tapping and still decide not to resume a relationship.

Emotional relief may mean:

- the event no longer dominates every thought;
- the person can discuss it without losing control;
- the urge for revenge has decreased;
- a clearer decision can be made;
- boundaries can be expressed more effectively.

It does not necessarily mean:

- trust has returned;
- the other person has changed;
- reconciliation is advisable;
- contact is safe;
- consequences should be withdrawn;
- the relationship should continue.

The APA Dictionary of Psychology explicitly distinguishes forgiveness from reconciliation, excusing the offence, merely accepting what occurred, or simply ceasing to feel anger.

9.21 Forgiveness as a Personal Process

Forgiveness may be meaningful for some people, but it should remain voluntary.

A person may work through several positions:

Not Ready

“I am not ready to forgive, and I acknowledge the part of me that remains protective.”

Reducing the Personal Burden

“I am willing to reduce the effect this anger has on my sleep and health.”

Preserving Boundaries

“Releasing part of the emotional burden does not require renewed access or trust.”

Considering Forgiveness

“I am open to exploring forgiveness without pressure to reconcile.”

Spiritual Reflection

"O Allah, guide me towards a response that is merciful, just, and safe."

The practitioner should not make forgiveness a condition of treatment success or religious worth.

9.22 Relationship Pain in Unsafe or Abusive Situations

Not every relationship conflict is a communication problem. Physical aggression, sexual coercion, psychological abuse, threats, isolation, financial control, stalking, and controlling behavior require a safety-centered response.

The World Health Organization defines intimate partner violence as behavior by a current or former partner that causes physical, sexual, or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviors. WHO recommends survivor-centered care, attention to safety, and coordination with health, legal, social, and child-protection services where appropriate.

In such circumstances, SEFT must not be used to:

- make the survivor more tolerant of abuse;
- promote joint disclosure in front of the abusive person;
- pressure reconciliation;
- encourage confrontation without safety planning;
- treat fear as irrational;
- suggest that prayer alone will change the perpetrator;
- delay medical, legal, or protective assistance.

A safer statement is:

"Even though I feel frightened and confused, my fear may be giving me important information. Help me become grounded enough to consider my safety and contact trustworthy support."

The immediate priorities may include:

- finding a safer location;
- contacting emergency or specialist services;
- obtaining medical care;
- preserving important documents;
- involving a trusted person;
- developing a safety plan;
- protecting children or vulnerable adults;
- seeking legal guidance.

Tapping may support emotional regulation while these actions are considered, but it is not a safety plan.

9.23 When Couple Work Is Inappropriate

Joint relationship work may be unsafe when one person:

- fears retaliation;
- cannot speak freely;
- is being monitored;
- experiences coercive control;
- is threatened after disclosure;
- has no meaningful ability to decline;
- faces continuing violence.

A practitioner should not assume that equal responsibility exists merely because two people are in the same relationship.

The statement:

“Both of you created this conflict”

may be seriously misleading where one person is using coercion or violence.

Individual safety assessment and specialist referral may be required before any shared intervention is considered.

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9.24 Spiritual Abuse

Spiritual or religious language can itself be used as a form of control.

Examples include:

- demanding obedience by claiming divine authority;
- describing abuse as a test that must be endured silently;
- using religious texts to prevent help-seeking;
- claiming that separation is always spiritually wrong;
- presenting the perpetrator’s forgiveness as more important than the survivor’s safety;
- suggesting that distress proves weak faith.

SEFT practitioners must not repeat these dynamics.

A spiritually safe statement is:

“My spiritual values do not require me to deny harm. I can seek protection, guidance, and justice while remaining connected with my faith.”

9.25 Relational Boundaries

A boundary identifies what a person will or will not participate in and what action they will take when a limit is crossed.

A boundary is not:

"You must change."

A boundary is:

"I will end the conversation if shouting or insults begin."

Or:

"I will not discuss this subject in front of the children."

SEFT may help reduce the fear or guilt associated with expressing a boundary:

"Even though I fear that setting this limit will cause rejection, I acknowledge that respectful relationships require limits. I can speak clearly without becoming aggressive."

The person should prepare for the possibility that the other individual may not respect the boundary. A boundary becomes meaningful through the person's own follow-through, not through control of another person.

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9.26 Spiritually Integrated Statements

Grief

"O Allah, I acknowledge how deeply I miss this person. Help me carry the loss without denying the love."

Anticipatory Grief

"I do not know what the coming weeks will bring. Help me remain present and make responsible decisions one day at a time."

Rejection

"This rejection hurts, but it does not contain the whole truth about my worth or future."

Humiliation

"Help me preserve my dignity without becoming trapped in revenge or self-condemnation."

Shame

"I acknowledge what I regret. Guide me towards responsibility, repair, and hope."

Betrayal

"Help me see the situation clearly and decide what protects my dignity and safety."

Forgiveness

"I am not ready to force forgiveness. Guide me towards a response that is truthful, just, and spiritually sincere."

Relationship Ending

"I grieve what I hoped this relationship would become. Help me release the future I imagined and face the life that is present."

9.27 Signs That Specialist Support Is Needed

Professional assessment should be sought when grief or relationship pain involves:

- persistent inability to perform ordinary responsibilities;
- severe isolation;
- intense grief that remains disabling;
- repeated traumatic images;
- prolonged sleep or appetite disturbance;
- substance misuse;
- severe depression;
- self-harm;
- suicidal thoughts;
- thoughts of harming another person;
- psychosis or mania;
- severe dissociation;
- stalking or obsessive pursuit;
- domestic or sexual violence;
- risk to children or vulnerable adults;
- inability to remain safe.

Relationship loss, high conflict, violence, social isolation, and hopelessness may contribute to suicide risk, although no single factor determines whether suicide will occur.

A practitioner should ask direct, respectful questions when risk is suspected rather than assuming that tapping has resolved the concern.

9.28 Evidence and Limitations

The available evidence does not justify describing SEFT as an established treatment for grief, rejection, shame, betrayal, or relationship trauma.

EFT tapping research has reported possible benefits for anticipatory grief in cancer populations, but these findings concern a particular medical context. Research on internalized shame supports structured psychosocial and compassion-based approaches more broadly, while evidence specifically evaluating tapping for shame remains limited.

There is even less direct evidence demonstrating that explicitly spiritual tapping produces better outcomes than:

- tapping without prayer;
- prayer without tapping;
- supportive counselling;
- grief-focused psychotherapy;
- compassion-focused intervention;
- another active treatment.

SEFT may therefore be described as an adjunctive emotional-regulation practice. Claims should remain proportionate to the evidence.

9.29 Chapter Summary

Grief, rejection, shame, and relationship pain involve more than a single negative emotion. They may affect identity, belonging, bodily regulation, trust, social connection, future expectations, and spiritual meaning.

Grief should not be forced into a fixed sequence or timetable. Most bereavement is painful but not pathological. Severe and persistent impairment may indicate prolonged grief disorder and requires appropriate assessment.

Rejection may produce anger, humiliation, shame, guilt, sadness, or withdrawal, depending partly on how the event is interpreted. SEFT can help separate an external outcome from a global judgment of personal worth.

Shame should be distinguished from guilt. Guilt can support responsibility and repair, while shame may define the entire person as defective. Tapping language should preserve accountability without permanent self-condemnation.

Emotional relief does not require reconciliation. Forgiveness is not identical to excusing an offence, restoring trust, removing consequences, or returning to an unsafe relationship.

Where abuse, coercion, stalking, or violence is present, safety and specialist support take priority. SEFT must never be used to make a person more tolerant of harm.

The guiding question is:

"How can I acknowledge this pain, preserve my dignity and safety, and take the next responsible step without denying what the relationship or loss meant to me?"

Practice Worksheet

Part A: Identify the Loss or Injury

My concern involves:

☐ Bereavement
☐ Anticipatory grief
☐ Relationship ending
☐ Rejection
☐ Shame or guilt
☐ Betrayal
☐ Family conflict
☐ Another loss

The specific event is:

What I lost or fear losing is:

The strongest present emotion is:

The bodily sensation is:

The intensity is:
_____ /10

Part B: Identify the Meaning

The event seems to say this about me:

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The event seems to say this about the other person:

What I know as fact is:

What I am assuming or fearing is:

Part C: Responsibility and Control

What was within my control?

What was outside my control?

Is repair possible or necessary?

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Part D: Set-Up Statement

"Even though _____
when I remember _____
I feel _____
and part of me believes _____
I acknowledge _____
and ask for _____

Part E: Boundary and Safety

Do I feel safe in this relationship or situation?
☐ Yes
☐ No
☐ Unsure

The boundary I may need is:

The support I may need is:

Part F: Reassessment

Intensity after tapping:
_____ /10

What changed?

What remains?

The next safe and responsible action is:

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Chapter 10

Physical Symptoms and Chronic Illness

Living with physical symptoms or chronic illness involves more than biological changes. Pain, fatigue, disability, treatment uncertainty, medical appointments, financial strain, altered family roles, and fear about the future may affect emotional well-being, identity, relationships, work, sleep, and spiritual life.

SEFT may provide a structured way to address some of this emotional burden. A person might use it to work with:

- fear before a medical procedure;
- distress associated with pain;
- frustration about physical limitations;
- anxiety while awaiting test results;
- fear of movement after injury;
- sadness about changes in independence;
- difficulty following a treatment routine;
- anger about delayed diagnosis;
- spiritual questions arising from illness.

Its role must nevertheless remain clear:

SEFT may support emotional regulation, but it does not diagnose disease, determine the cause of a symptom, replace medication, heal damaged tissue, or substitute for appropriate medical treatment.

A reduction in discomfort after tapping may be meaningful, but it does not prove that the underlying disease has resolved. Similarly, unchanged pain does not indicate weak faith, unconscious resistance, or failure to perform the technique correctly.

10.1 Pain Is Both Sensory and Emotional

The International Association for the Study of Pain defines pain as an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage. Its accompanying principles emphasize that pain is personal, influenced by biological, psychological, and social factors, and should be respected when reported by the person experiencing it.

This definition has several important implications.

First, pain is real even when its cause is difficult to identify. A normal scan or laboratory result does not prove that a person is inventing the experience.

Second, the emotional dimension of pain does not mean that pain is "only psychological." Injury, inflammation, nerve changes, illness, stress, sleep, fear, attention, previous experiences, mood, and social circumstances may interact.

Third, reducing fear or emotional tension may change how pain is experienced without necessarily changing the medical condition responsible for it.

The aim of SEFT should therefore be framed carefully:

"We are working with the distress, fear, tension, or helplessness associated with the pain."

This is more accurate than:

"We are tapping away the disease."

10.2 Chronic Primary and Chronic Secondary Pain

NICE distinguishes between **chronic primary pain** and **chronic secondary pain**.

Chronic primary pain is persistent pain for which no underlying condition adequately explains the pain or its impact. Chronic secondary pain is associated with an identifiable condition, such as arthritis, cancer, endometriosis, neuropathy, or another disease process. The two forms may coexist.

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This distinction helps prevent two common errors.

Error 1: Assuming That Unexplained Pain Is Imaginary

The absence of a clear structural explanation does not invalidate pain.

Error 2: Assuming That All Pain Is Emotionally Generated

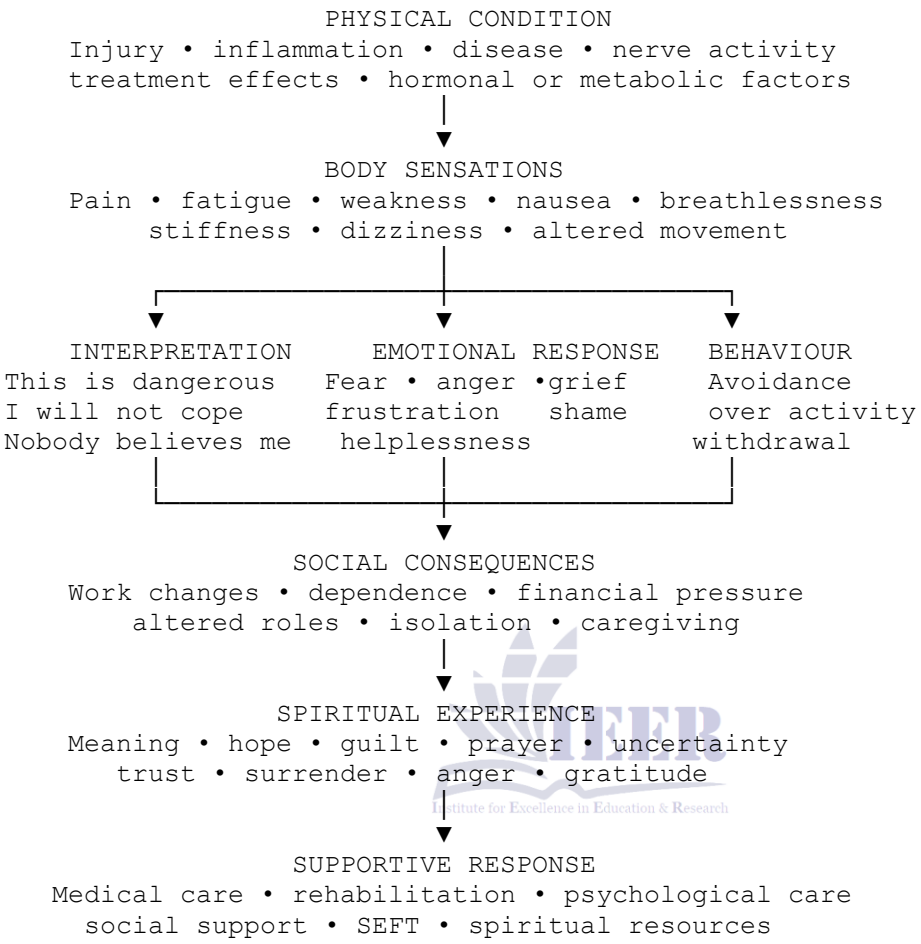
Pain associated with disease, tissue injury, inflammation, nerve damage, or treatment requires appropriate medical management. Emotional regulation may support coping but does not remove the biological condition.

NICE recommends a person-centered assessment of chronic pain, including its nature, impact, contributing factors, daily functioning, sleep, psychological well-being, social circumstances, and the person's priorities.

SEFT may form one small component within such a broader plan.

Figure 10

A Biopsychosocial-Spiritual View of Physical Symptoms



Note. The model does not suggest that thoughts or emotions cause every physical symptom. It shows that biological, psychological, behavioral, social, and spiritual factors can influence the total illness experience.

10.3 The Appropriate Targets of SEFT

When illness is present, the safest SEFT target is usually not the diagnosis itself.

Instead of:

“This cancer.”

“My diabetes.”

“My damaged knee.”

Select an emotional, cognitive, behavioral, or bodily aspect:

“The fear I feel when I hear the word cancer.”

“My frustration about checking my blood glucose every day.”

“The tension that appears when I prepare for physiotherapy.”

“The memory of receiving the diagnosis.”

“My fear that movement will damage the joint again.”

“The loneliness I feel when other people do not understand my fatigue.”

“My anger about needing assistance.”

This distinction avoids suggesting that tapping is directly treating the disease.

Suitable SEFT Targets

1. Pain-related fear
2. Distress about symptoms
3. Medical-procedure anxiety
4. Treatment-related uncertainty
5. Fear of movement
6. Frustration with limitations
7. Grief about changed functioning
8. Embarrassment about visible symptoms
9. Anxiety about medication
10. Spiritual distress associated with illness

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Targets Requiring Medical Assessment First

- new or unexplained pain;
- rapidly worsening symptoms;
- sudden weakness or loss of function;
- significant breathing difficulty;
- chest pressure;
- loss of consciousness;
- severe allergic symptoms;
- uncontrolled bleeding;
- sudden neurological changes;
- symptoms following a serious injury.

SEFT may provide emotional support while appropriate help is obtained, but it should not delay medical evaluation.

10.4 Symptom Versus Reaction to the Symptom

A useful assessment separates three levels.

Level 1: The Physical Symptom

"There is pain in my right knee."

Level 2: The Emotional Reaction

"I feel frightened and frustrated."

Level 3: The Interpretation

"This pain means I will lose my independence."

The person may tap for the fear and catastrophic interpretation while continuing medical assessment of the knee.

A set-up statement could be:

"Even though this knee pain frightens me and part of me imagines that I will lose my independence, I acknowledge both the pain and the fear. I will follow appropriate medical advice and work with the emotional pressure I feel now."

The person is not required to decide whether the pain is physical or emotional. The experience can contain both physical sensation and emotional meaning.

10.5 Do Not Search for a Hidden Emotion Behind Every Symptom

Some mind–body teachings suggest that every symptom represents one specific unresolved emotion. Examples include claims that:

- shoulder pain means excessive responsibility;
- back pain means lack of support;
- cancer results from resentment;
- diabetes reflects an inability to receive love;
- thyroid illness reflects unspoken feelings.

Such interpretations should not be presented as medical facts.

They may lead to:

- delayed diagnosis;
- guilt;
- blame;

- unnecessary family conflict;
- withdrawal from medical treatment;
- false certainty about causation.

A practitioner may ask neutrally:

“Does stress appear to influence this symptom?”

The practitioner should not declare:

“This symptom proves that you are suppressing anger.”

Emotional exploration should remain exploratory rather than diagnostic.

10.6 Applying SEFT to Pain-Related Distress

Pain should be assessed through more than intensity alone.

Useful questions include:

- Where is the pain?
- What does it feel like?
- How long has it been present?
- Has it been medically assessed?
- What activities does it interfere with?
- What emotion arises with it?
- What does the person fear the pain means?
- Does the person avoid movement?
- Does the person overexert and then collapse?
- How is sleep affected?
- What treatment is already being used?

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The SEFT practitioner should not conduct a medical diagnosis unless separately qualified to do so.

Three Ratings

For pain-related work, record:

1. Pain intensity: 0–10
2. Emotional distress: 0–10
3. Interference with functioning: 0–10

These ratings may change differently.

For example:

- pain intensity may remain at 6;
- emotional distress may decrease from 8 to 4;
- willingness to complete prescribed exercises may increase.

This would represent a potentially useful change even though the pain has not disappeared.

10.7 Basic Pain-Distress Protocol

Step 1: Identify the Symptom

"A burning sensation across the lower back."

Step 2: Confirm Medical Context

"The symptom has been assessed, and I am following the treatment plan."

Step 3: Identify the Emotional Target

"I feel afraid that the pain will become permanent."

Step 4: Establish Ratings

Pain: 6/10
Fear: 8/10
Interference: 7/10

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Step 5: Set-Up Statement

"Even though I feel this burning pain in my lower back and fear that it will never improve, I acknowledge both the discomfort and the fear. O Allah, help me remain steady, follow appropriate treatment, and respond to my body with wisdom."

Step 6: Tapping Round

Top of head:

"This burning pain."

Eyebrow:

"The fear that it will remain forever."

Side of eye:

"I am tired of living with this."

Under eye:

"My whole attention goes towards the pain."

Under nose:

"Part of me is constantly preparing for it to worsen."

Chin:

"This fear and frustration."

Collarbone:

"I can acknowledge the pain without predicting the entire future."

Under arm:

"I can follow my treatment plan one step at a time."

Top of head:

"I ask for patience, appropriate care, and wise action."

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Step 7: Reassess Separately

Record pain, distress, and interference again.

Do not tell the person that pain must decrease. Emotional distress may change first.

10.8 Pain Catastrophizing

Pain catastrophizing refers to patterns such as magnifying the threat of pain, feeling helpless, and becoming unable to shift attention away from it.

Examples include:

"This will never end."

"My body is completely damaged."

"I cannot do anything while this pain is present."

A SEFT statement should not dismiss the symptom:

"The pain is not real."

A more balanced statement is:

"The pain is real, and my mind is also predicting the worst possible future. I can separate what I feel now from what I fear may happen."

A 2025 randomized study following total knee arthroplasty reported reductions in pain catastrophizing, pain intensity, and pain sensitivity after a four-week EFT intervention. Such findings are encouraging but remain condition-specific and should not be generalized to every type of acute or chronic pain.

10.9 Fear of Movement

After injury, surgery, or prolonged pain, a person may become afraid that movement will cause further damage. This fear is sometimes referred to as **kinesiophobia**.

Fear of movement can be reasonable when activity is medically restricted. It may become unhelpful when fear continues after a clinician has advised that gradual movement is safe.

SEFT must not be used to override medical restrictions.

Before working with movement fear, clarify:

- Has movement been medically or physiotherapeutically assessed?
- Which movements are permitted?
- Which movements should be avoided?
- What sensations are expected?
- What warning signs require stopping?
- Is the fear greater than the actual restriction?

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Movement-Fear Statement

"Even though I feel frightened when I prepare to bend my knee, I will not force the movement. I am willing to follow the safe range recommended by my physiotherapist."

Tapping Round

"This fear of bending."

"The memory of the pain after surgery."

"Part of me expects damage."

"I can move only within the advised range."

"I can pause and communicate if something feels wrong."

A 2025 single-arm feasibility study involving 20 people with rheumatoid arthritis found that an adapted four-week EFT intervention was acceptable and feasible and reported improvements in movement fear and secondary outcomes. Because it had no randomized comparison group and a small sample, it supports further research rather than conclusions about established effectiveness.

10.10 The Difference Between Pacing and Avoidance

People with chronic symptoms may alternate between:

- doing too much on a relatively good day;
- experiencing increased symptoms;
- resting for an extended period;
- feeling guilty;
- overexerting again.

Pacing involves planning activity according to realistic capacity rather than waiting until exhaustion or pain forces the person to stop.

SEFT may address beliefs that interfere with pacing:

“If I rest, I am lazy.”

“I must finish everything while I feel slightly better.”

“Other people will think I am making excuses.”

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A set-up statement might be:

“Even though I feel guilty about stopping before the task is complete, pacing is part of responsible symptom management. I can respect my current capacity without defining myself as lazy.”

The actual activity plan should be developed with relevant healthcare professionals where necessary.

10.11 Pain, Sleep, and Emotional Activation

Pain can disturb sleep, while insufficient sleep may make pain and emotional regulation more difficult. Worry about not sleeping can add another layer of activation.

A useful target is:

“The anxiety that begins when I look at the clock.”

Possible statement:

"Even though I am afraid that another difficult night will make tomorrow impossible, I acknowledge the worry without forcing sleep. I can follow my treatment plan and allow my body to rest as much as it can."

Persistent sleep problems should be medically assessed, particularly when they involve breathing interruptions, severe daytime sleepiness, medication effects, or another health concern.

10.12 Chronic Illness and Emotional Adjustment

A chronic diagnosis may alter a person's understanding of the future.

Common emotional responses include:

- shock;
- disbelief;
- anger;
- fear;
- sadness;
- relief that symptoms have an explanation;
- guilt about dependence;
- shame about visible changes;
- grief for previous functioning;
- concern about finances;
- uncertainty about treatment;
- spiritual questioning.

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These reactions may recur when:

- treatment changes;
- a symptom worsens;
- another appointment approaches;
- the person encounters a new limitation;
- a medical result is received;
- the person compares themselves with others.

Adjustment is not a one-time event.

A person can accept that a condition exists and still feel anger or grief about its impact.

10.13 Diagnosis-Related Shock

The moment of diagnosis may become a distressing memory.

Possible targets include:

- the physician's expression;

- a particular medical word;
- the sound of the clinic;
- the sentence, "This is a chronic condition";
- the journey home;
- the first conversation with family.

Set-Up Statement

"Even though I still hear the physician saying that this condition is chronic, and my body reacts as if I am hearing it for the first time, I acknowledge the shock. O Allah, help me process this information gradually and seek the care and knowledge I need."

Reminder Phrases

"That sentence."

"The shock in my chest."

"The future I imagined changing."

"I do not have to understand everything today."

"I can ask questions gradually."

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10.14 Loss of Identity

A person may say:

"I am no longer useful."

"I have become a burden."

"My illness has taken away who I am."

The condition may have changed important roles, but it should not automatically become the person's entire identity.

A SEFT statement might be:

"Even though this illness has changed what I can do, I acknowledge the grief connected with those changes. I am more than a diagnosis, and I can explore forms of contribution that fit my present capacity."

This should not be used to minimize real losses. The person may need vocational support, rehabilitation, financial assistance, assistive technology, family adjustment, or disability accommodations.

WHO describes rehabilitation as an important part of care for chronic health conditions because it can support functioning, self-management, participation, and quality of life.

10.15 Dependence and Receiving Help

People who value independence may find it painful to accept assistance.

Possible beliefs include:

“Needing help means I have failed.”

“My family will become tired of me.”

“I must hide how difficult this is.

A possible statement is:

“Even though I feel ashamed when I need assistance, receiving appropriate help does not remove my dignity. I can communicate my needs and remain considerate of other people’s limits.”

The goal is neither complete dependence nor refusal of help. It is a realistic balance of autonomy, support, safety, and mutual respect.

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10.16 Medical-Procedure Anxiety

Medical anxiety may arise before:

- blood tests;
- imaging;
- injections;
- surgery;
- dental procedures;
- chemotherapy;
- radiotherapy;
- rehabilitation;
- endoscopy;
- follow-up appointments.

The fear should be made specific.

Ask:

“Which part of the procedure worries you most?”

Possible answers include:

- pain;
- needles;
- loss of control;
- embarrassment;
- anesthesia;
- receiving bad news;
- being alone;
- a previous medical experience;
- not understanding instructions.

Procedure-Anxiety Protocol

Specific target:
The moment the needle approaches.

Initial anxiety:
8/10.

Set-Up:

"Even though my body becomes tense when I imagine the needle approaching, I acknowledge this fear. Help me remain present, communicate with the medical team, and use the support available to me."

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Tapping phrases:

"The approaching needle."

"This tension in my hands."

"The fear of losing control."

"I can tell the clinician that I am anxious."

"I can ask them to explain each step."

"I can look away if that helps."

"I can pause when medically possible."

SEFT should not interfere with sterile procedures, monitoring equipment, positioning, or medical instructions. Tapping may be completed before the procedure or only with staff permission.

10.17 Waiting for Results

Waiting can activate catastrophic thinking because the outcome is unknown.

A supportive statement is:

"Even though my mind keeps imagining the worst result, I do not yet know the outcome. I will attend the appointment, ask the necessary questions, and return my attention to what is present today."

This does not require false reassurance:

"The result will certainly be normal."

The aim is to distinguish uncertainty from certainty of disaster.

10.18 Fear of Recurrence or Deterioration

People living with serious or recurring illness may monitor every sensation for evidence that the condition has returned or worsened.

A SEFT target could be:

"The fear activated by this new sensation."

The statement should include medical responsibility:

"Even though this sensation has activated my fear of recurrence, I acknowledge the anxiety. I will follow the monitoring advice given by my medical team and avoid deciding the meaning of the symptom through fear alone."

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The person should know whom to contact and which symptoms require medical review.

10.19 Cancer-Related Distress and Pain

A 2025 randomized controlled trial involving 70 people with cancer compared four structured EFT sessions plus routine care with routine care alone. The intervention group reported larger reductions in pain and depression after two weeks. The study provides preliminary support for EFT as an adjunctive intervention but does not show that tapping treats cancer itself, replaces analgesia, or changes disease progression.

SEFT-specific research has also examined pain in people with advanced breast cancer, but the small and developing evidence base does not establish SEFT as a standard cancer-pain intervention.

Cancer-related SEFT should focus on:

- emotional distress;
- procedure anxiety;
- fear of pain;

- grief;
- uncertainty;
- communication;
- coping with treatment.

It must remain coordinated with oncology and palliative-care services.

10.20 Medication and Treatment Adherence

Medication-taking is not simply obedience. NICE defines adherence as the extent to which a person's actions match recommendations that have been agreed with a healthcare professional. The guideline emphasizes shared decision-making, respectful communication, informed choice, and exploration of practical or belief-related barriers.

People may struggle with treatment because of:

- side effects;
- cost;
- complicated schedules;
- forgetfulness;
- fear of dependency;
- stigma;
- lack of perceived benefit;
- conflicting advice;
- difficulty swallowing;
- transportation problems;
- spiritual beliefs;
- hopelessness;
- mistrust;
- misunderstanding of instructions.

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A SEFT practitioner should not label all no adherence as resistance.

Ask:

"What makes following this treatment difficult?"

The answer may require a pharmacist, physician, nurse, financial service, family support, or a simpler treatment plan not more tapping.

10.21 SEFT for Treatment-Related Fear

A person may understand the medical recommendation but feel too anxious to follow it.

Example

"I know the physician prescribed the medication, but I become frightened each time I prepare to take it because I fear side effects."

A possible set-up is:

"Even though I feel afraid when I prepare to take this medicine, I acknowledge that fear. I will not change the dose independently. I can write down my concerns and discuss them with the prescriber or pharmacist."

The next action may be:

- reviewing the patient-information leaflet;
- contacting the prescriber;
- asking about expected side effects;
- clarifying timing;
- discussing cost;
- requesting a medication review.

SEFT should support communication rather than encourage unsupervised changes.

10.22 Medication Boundaries

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Unless medically qualified and acting within that role, the practitioner must not advise a person to:

- stop medication;
- reduce a dose;
- increase a dose;
- replace medication with tapping;
- discontinue insulin;
- stop psychiatric medication;
- avoid chemotherapy;
- stop anticoagulants;
- abandon rehabilitation;
- ignore side effects.

A reduction in symptoms after tapping does not prove that treatment is no longer necessary.

The practitioner may say:

"Please discuss any medication change with the prescribing clinician. We can use SEFT to work with the anxiety or frustration associated with that conversation."

10.23 Treatment Fatigue

Long-term treatment may become emotionally exhausting.

A person may feel:

“I am tired of appointments.”

“I do not want to think about illness every day.”

“My whole life has become treatment.”

A set-up statement might be:

“Even though I feel exhausted by the constant appointments and routines, I acknowledge this treatment fatigue. Help me identify what support or adjustment may make the plan more manageable.”

The practical response may include:

- consolidating appointments;
- using reminders;
- involving family support;
- speaking with a pharmacist;
- discussing treatment burden;
- seeking psychological care;
- requesting rehabilitation or social support.

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CDC guidance for people living with chronic conditions emphasizes regular healthcare follow-up, self-management, informed decision-making, and checking relevant health measures as recommended.

10.24 Spiritual Meaning in Chronic Illness

Illness may strengthen spiritual connection, but it may also create spiritual conflict.

A person may ask:

“Why has this happened?”

“Am I being punished?”

“Why has prayer not removed the illness?”

“Can I still have a meaningful life?”

"How do I surrender without giving up?"

The practitioner should not provide simple theological explanations for complex suffering.

Avoid:

"The illness was sent because you needed to learn patience."

"Your faith will cure you."

"You remain ill because you have not forgiven someone."

A spiritually respectful statement is:

"Even though I do not understand why I am facing this illness, I acknowledge the fear and confusion. O Allah, help me seek treatment, use the strength available to me, and find meaning without blaming myself."

10.25 Prayer and Medical Treatment

Prayer and medical treatment do not need to be presented as opposites.

A person may pray for:

- healing;
- relief;
- patience;
- accurate diagnosis;
- wise clinicians;
- courage;
- family support;
- acceptance;
- strength to follow treatment;
- a peaceful death when appropriate.

Spiritual surrender does not require stopping treatment.

A balanced statement is:

"I will follow the care available to me, ask questions, and place the final outcome in Allah's hands."

This respects both personal responsibility and spiritual trust.

10.26 When Improvement Does Not Occur

Some people will experience no meaningful change after SEFT.

The practitioner should not conclude that:

- the person does not want to recover;
- faith is insufficient;
- the illness is serving an unconscious purpose;
- the technique is working invisibly;
- distress must increase before healing;
- more intense tapping is required.

A respectful response is:

"The technique has not produced a noticeable improvement in this target. We should consider another approach or discuss the concern with the relevant healthcare professional."

The absence of benefit is clinically important information.

10.27 Evidence Concerning EFT and Chronic Pain

A 2025 randomized clinical trial included 147 adults with chronic pain who completed either a live online or self-paced six-week EFT intervention. Compared with a wait-list condition, EFT was associated with reductions in pain severity and interference and improvements in quality of life, with some findings maintained at six months. The study found no significant intervention effects for anxiety, depression, happiness, or life satisfaction. The authors described the findings as early evidence and identified limitations.

This trial is stronger than an uncontrolled case series, but it does not establish that EFT is effective for every pain condition. The sample was predominantly female, interventions were delivered online, and the study compared two EFT formats with a wait-list rather than with a comprehensive multidisciplinary pain intervention.

The findings concern EFT, not necessarily spiritually integrated SEFT. Research would need to compare:

- EFT without spiritual content;
- prayer or spiritual care alone;
- combined SEFT;
- established psychological treatment;
- usual multidisciplinary care.

Without such comparisons, the additional contribution of SEFT's spiritual component remains uncertain.

10.28 Evidence Should Be Interpreted by Outcome

A study may report improvement in one outcome but not another.

Possible outcomes include:

- pain intensity;
- pain interference;
- emotional distress;
- depression;
- fear of movement;
- quality of life;
- sleep;
- medication use;
- physical functioning;
- biological markers.

Improvement in distress does not automatically demonstrate improvement in disease activity. Reduced pain does not necessarily indicate tissue healing. A change in a laboratory marker does not, by itself, establish meaningful clinical recovery.

Researchers and practitioners should report exactly what changed and avoid expanding the conclusion beyond the measured outcome.

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10.29 Supportive SEFT Care Plan

A practical care plan may include five domains.

Domain	Central question	Possible response
Medical	What diagnosis, monitoring, or treatment is needed?	Physician, medication, procedure, investigation
Functional	What helps the person remain active and independent?	Rehabilitation, pacing, assistive device, accommodation
Emotional	What fear, grief, anger, or helplessness is present?	SEFT, counselling, psychotherapy, support group
Social	What practical or relational support is needed?	Family assistance, financial advice, workplace support
Spiritual	What beliefs, values, or struggles are active?	Prayer, spiritual care, meaning-centered discussion

SEFT belongs mainly within the emotional and spiritual domains. It may indirectly support functioning and treatment participation, but it does not replace the medical domain.

10.30 Monitoring a Session

Record:

Medical context:
Has the symptom been assessed?

Physical target:
What sensation is being noticed?

Emotional target:
What reaction accompanies it?

Pain intensity:
____ /10

Emotional distress:
____ /10

Functional interference:
____ /10

Treatment plan:
What care is already being followed?

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SEFT outcome:
What changed after tapping?

Medical follow-up:
Is further assessment needed?

Practical action:
What will the person do next?

This structure prevents an emotional intervention from being mistaken for medical treatment.

10.31 When to Stop and Refer

Stop SEFT and seek appropriate assessment when:

- the symptom is new, severe, or rapidly worsening;
- an acute medical emergency is suspected;
- tapping increases physical pain substantially;
- the person becomes faint or confused;
- the person has not received appropriate assessment;
- treatment is being discontinued without medical advice;

- severe depression, self-harm, or suicidal thinking emerges;
- the person is unable to care for basic needs;
- the practitioner's competence has been exceeded.

Referral is not failure. It is part of ethical care.

10.32 Chapter Summary

Physical symptoms and chronic illness involve biological, psychological, social, behavioral, and spiritual dimensions. Recognizing emotional influences does not mean that symptoms are imaginary or caused entirely by thoughts.

SEFT may be used to address pain-related fear, medical anxiety, frustration, grief, treatment fatigue, fear of movement, uncertainty, and spiritual struggle. The safest target is generally the person's reaction to the symptom rather than a claim that tapping is treating the disease itself.

Pain intensity, emotional distress, and functional interference should be assessed separately. A person may become less frightened even when pain remains present. This may support clearer thinking, communication, pacing, rehabilitation, or treatment participation.

Research on EFT for chronic pain and cancer-related symptoms is encouraging but still limited. Findings should be interpreted according to the exact population, comparison condition, intervention, and outcome measured. Evidence concerning specifically spiritual SEFT remains less developed.

Practitioners must not diagnose disease, interpret every symptom as emotional, advise medication changes outside their professional role, or claim that improvement proves physical healing.

The central principle is:

SEFT may help a person carry the emotional burden of illness, but it must remain part of, not a replacement for, safe, evidence-informed and person-centered healthcare.

Practice Worksheet

Part A: Medical Context

The diagnosed condition or symptom is:

This has been medically assessed:
☐ Yes
☐ No
☐ Assessment is ongoing

Current treatment or rehabilitation plan:

Healthcare professional involved:

Part B: Select the SEFT Target

I want to work with:

☐ Pain-related fear
☐ Medical-procedure anxiety
☐ Frustration
☐ Treatment fatigue
☐ Fear of movement
☐ Grief about changed functioning
☐ Waiting for results
☐ Spiritual distress
☐ Another emotional concern

The specific target is:

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Physical symptom intensity:
_____ /10

Emotional distress:
_____ /10

Functional interference:
_____ /10

Part C: Identify the Meaning

The thought connected with the symptom is:

What I fear it means is:

What is medically known is:

What remains uncertain is:

Part D: Set-Up Statement

Even though I feel _____
when I notice _____
I acknowledge _____
I will continue _____
and ask for _____

Part E: Reassessment

Physical symptom after tapping:
_____ /10

Emotional distress after tapping:
_____ /10

Functional interference after tapping:
_____ /10

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What changed:

What did not change:

The medical or practical action I will take is:

Chapter 11

Trauma-Informed SEFT

Traumatic experiences can affect memory, emotion, bodily regulation, attention, identity, relationships, behavior, and spiritual meaning. A person may remain aware that an event occurred in the past while part of the body continues to respond as though danger is present.

Possible reactions include:

- intrusive memories or nightmares;
- avoidance of reminders;
- persistent alertness;
- sleep disturbance;
- irritability or anger;
- emotional numbness;
- shame or guilt;
- difficulty concentrating;
- disconnection from the body or surroundings;
- difficulty trusting other people;
- negative beliefs about the self;
- spiritual confusion.

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Many reactions lessen naturally with time and support. Professional assessment becomes important when symptoms remain severe, persist, create substantial functional impairment, or involve risks to safety.

SEFT may sometimes support grounding and emotional regulation after trauma. However, regulating a symptom is not the same as treating post-traumatic stress disorder. Trauma treatment requires assessment, case formulation, risk management, therapeutic competence, monitoring, and an evidence-informed plan.

NICE recommends individual trauma-focused cognitive behavioral interventions for adults with PTSD or clinically important PTSD symptoms and recommends EMDR in defined circumstances. These treatments should be manual-based, phased appropriately, delivered by trained practitioners with ongoing supervision, and include management of arousal and flashbacks, trauma-memory processing, work with trauma-related meanings and emotions, and restoration of functioning.

NICE does not currently list EFT as a recommended first-line PTSD treatment. Instead, it identifies the clinical and cost-effectiveness of EFT for adult PTSD as a question requiring further research.

The position of this book is therefore:

SEFT may be used cautiously as a stabilization or complementary emotional-regulation practice, but it should not be represented as a complete or established treatment for PTSD.

11.1 Trauma-Informed Is Not the Same as Trauma-Focused

The terms *trauma-informed* and *trauma-focused* are sometimes used interchangeably, but they describe different levels of care.

Trauma-Informed Practice

A trauma-informed approach recognizes that a person may have experienced trauma and aims to avoid repeating dynamics of helplessness, coercion, humiliation, secrecy, or loss of control.

SAMHSA describes trauma-informed care as recognizing the widespread impact and signs of trauma, integrating this knowledge into practice, and actively attempting to resist re-traumatization. Its central principles include safety, trustworthiness, transparency, collaboration, empowerment, voice, and choice.

Trauma-informed SEFT therefore includes:

- explaining what will happen;
- obtaining continuing consent;
- preserving choice;
- allowing the person to stop;
- avoiding forced disclosure;
- respecting physical boundaries;
- working at a manageable intensity;
- monitoring orientation and safety;
- referring beyond the practitioner's competence.

Trauma-Focused Treatment

Trauma-focused treatment directly addresses traumatic memories, trauma-related beliefs, avoidance, emotional responses, and associated patterns of functioning.

This requires more than asking someone to remember an event while tapping. Evidence-based PTSD treatment is structured, delivered by trained practitioners, and includes careful assessment and monitoring.

A practitioner may work in a trauma-informed way without being qualified to provide trauma-focused psychotherapy.

11.2 SEFT Practitioner Roles

A practitioner's appropriate role depends on training and professional qualifications.

General SEFT Practitioner

A general practitioner may:

- teach low-intensity grounding;
- demonstrate tapping points;
- help with ordinary stress;
- use content-free language;
- support present-moment orientation;
- encourage appropriate referral.

The practitioner should not independently process severe trauma memories.

Mental-Health Professional Without Specialist Trauma Training

A psychologist, counsellor, social worker, nurse, physician, or practitioner may have broad clinical training without specific competence in trauma-focused treatment.

Such a professional may:

- assess general functioning and risk within their scope;
- provide stabilization;
- integrate SEFT cautiously with established care;
- refer for specialist trauma treatment.

Professional status alone does not establish competence in every trauma intervention.

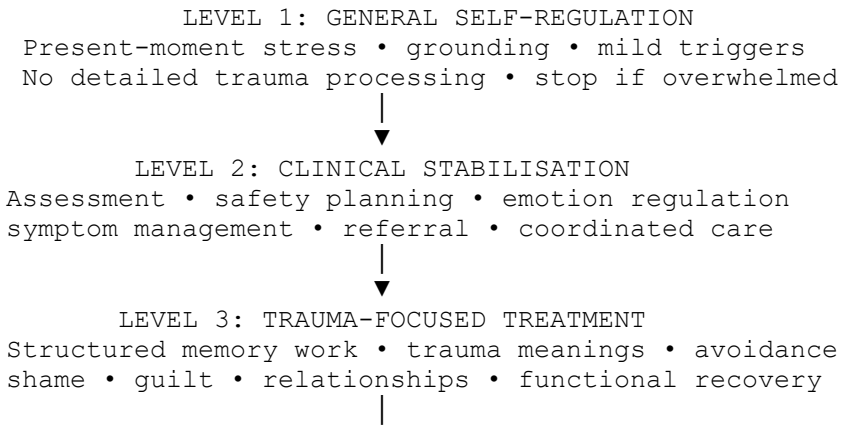
Trauma-Trained Mental-Health Professional

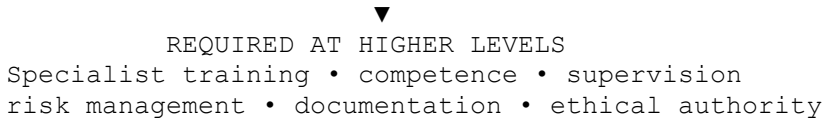
A practitioner with recognized trauma-treatment training, clinical experience, supervision, and legal authority may consider integrating SEFT as an adjunct within a broader treatment plan.

Even at this level, the practitioner should not replace established PTSD treatment merely because tapping appears to produce rapid subjective relief.

Figure 11

Levels of Trauma-Related SEFT Practice





Note. Completing a short course in tapping does not by itself qualify a person to provide trauma-focused psychotherapy.

11.3 Establishing Present Safety

Before working with a trauma-related concern, determine whether the danger is past, ongoing, or uncertain.

A person may still be exposed to:

- domestic violence;
- stalking;
- sexual coercion;
- threats;
- armed conflict;
- unsafe housing;
- workplace harassment;
- trafficking;
- child abuse;
- community violence;
- repeated medical procedures;
- contact with the perpetrator.

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When danger is ongoing, calming the person is not the primary solution. The priority may be safeguarding, emergency assistance, medical care, legal support, secure accommodation, or a coordinated safety plan.

A spiritually framed statement should never suggest that the person must surrender to continuing abuse:

“I accept that this is happening and place it in God’s hands.”

A safer statement is:

“Even though I feel frightened and confused, this fear may be giving me important information. O Allah, help me become clear enough to seek safety and trustworthy support.”

Emotional regulation should strengthen protective action, not reduce a person’s ability to recognize danger.

11.4 Immediate Aftermath of Trauma

In the immediate aftermath of a traumatic event, people often need:

- physical safety;
- medical attention;
- practical assistance;
- accurate information;
- connection with supportive people;
- access to shelter, food, transport, or communication;
- protection from further exposure.

Psychological First Aid focuses on humane, practical, supportive assistance rather than requiring people to describe traumatic details. It aims to reduce initial distress, support safety, address practical needs, and connect people with resources.

NICE advises against psychologically focused debriefing for the prevention or treatment of PTSD. This means that survivors should not be pressured into a single-session detailed retelling on the assumption that immediate emotional disclosure will prevent later symptoms.

SEFT in this early period should therefore remain simple:

“I am here now.”

“My body has been through something frightening.”

“I can feel my feet against the ground.”

“I only need to manage this moment.”

“I can accept practical help.”

Detailed memory processing should not be initiated merely because the event is recent and emotionally active.

11.5 The Principle of Stabilization

Stabilization means helping the person remain sufficiently connected with the present while managing emotional activation.

It may involve:

- orientation to time and place;
- awareness of the physical environment;
- regulation of breathing without forcing it;
- identifying supportive people;

- planning for sleep and basic needs;
- reducing immediate risk;
- learning how to pause a session;
- recognizing early warning signs;
- establishing predictable routines.

Stabilization does not mean that the person must become completely symptom-free before receiving trauma-focused treatment. It means that barriers such as immediate danger, severe dissociation, uncontrolled substance use, emotional dysregulation, or serious self-harm risk must be considered and managed within the treatment plan. NICE recommends allowing additional time to build trust and addressing barriers to trauma-focused therapy for people with complex needs.

11.6 A Practical Window of Tolerance

The term **window of tolerance** can be used as a practical metaphor for the range in which a person remains emotionally activated but still able to:

- recognize the present environment;
- understand spoken language;
- communicate choices;
- reflect on the experience;
- pause when needed;
- distinguish memory from current reality.

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Above the Manageable Range

The person may experience:

- panic;
- intense agitation;
- rapid speech;
- trembling;
- rage;
- racing thoughts;
- uncontrollable crying;
- an urge to escape or attack.

Below the Manageable Range

The person may experience:

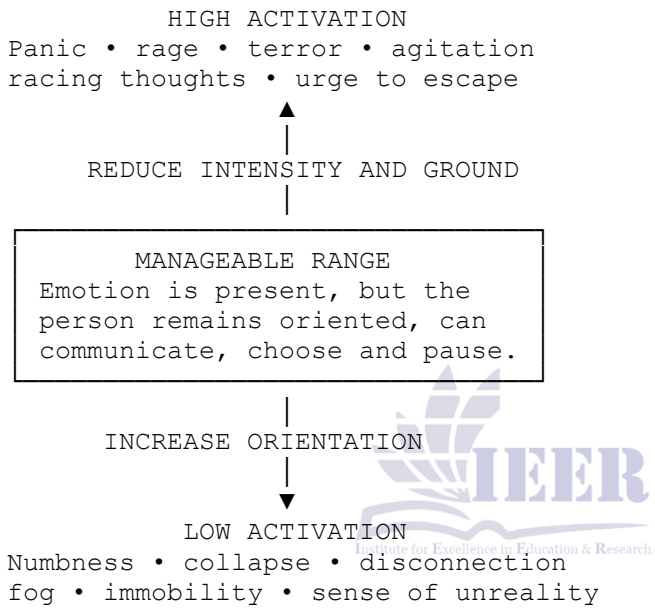
- numbness;
- mental fog;
- extreme tiredness;
- immobility;
- emotional disconnection;

- reduced speech;
- a sense of unreality;
- inability to feel the body.

The goal is not to remain perfectly calm. The goal is to maintain enough present awareness and choice for the work to remain useful.

Figure 12

The Manageable Range for Trauma-Informed SEFT



Note. This diagram is a clinical teaching aid rather than a diagnostic measurement. A person may move rapidly between high and low activation.

11.7 Orientation Before Emotional Contact

Before approaching a trauma-related target, ask the person to notice:

1. their name;
2. the current date;
3. the present location;
4. the difference between the current room and the location of the event;
5. the door or exit;
6. the support of the chair;
7. the contact of both feet with the floor;
8. one neutral object in the room;
9. one sound occurring now;
10. the practitioner's voice.

A useful statement is:

"The memory concerns something that happened then. You are noticing it from this room, on this date, and you can stop at any time."

This distinction is particularly important when a memory feels immediate rather than historical.

11.8 Resource Before Trigger

Before tapping on distress, identify something that supports present stability.

A resource may be:

- a trusted person;
- a safe room;
- a comforting prayer;
- a meaningful object;
- a pet;
- a memory of strength;
- awareness of personal survival;
- the ability to leave the room;
- professional support;
- a calm sensory experience.

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The person might tap gently while saying:

"I am sitting in this room now."

"I can feel the chair supporting me."

"I can choose how close I come to the memory."

"I know whom I can contact after this session."

"O Allah, help me remain connected with the present."

The resource should not be used to deny distress. It creates a stable reference point to which the person can return.

11.9 Establishing a Stop Procedure

A trauma-related session requires a clear stopping procedure.

Agree in advance that the person can:

- raise a hand;

- say “stop”;
- lower the tapping hand;
- stand up;
- move attention to the room;
- end the session.

When the signal is used, the practitioner must stop immediately.

Do not say:

“Continue for a little longer; you are almost through it.”

“This is only resistance.”

“The emotion must peak before it clears.”

These statements remove control and may repeat the helplessness associated with the original trauma.

After stopping, ask:

“Would you prefer silence, orientation, water, distance from the memory, or to end the session?”

11.10 Baseline Assessment

Before trauma-related tapping, record more than a distress number.

Present Distress

“How strong is the reaction now from 0 to 10?”

Orientation

“How connected do you feel with the present room?”

Emotional Control

“Can you choose to move attention away from the memory?”

Body Awareness

“Can you feel your feet, hands, and the support beneath you?”

Safety

“Is there any immediate risk to you or another person?”

Support

"What support is available after the session?"

The person may have moderate distress but poor orientation. In that situation, the session should focus on stabilization rather than memory processing.

11.11 Titration: Working in Small Amounts

Titration means approaching traumatic material in small, manageable portions.

The person does not need to describe the entire event. A target may be:

- the title of the event;
- the first safe moment before it occurred;
- one image viewed from a distance;
- the discomfort about discussing it;
- the bodily reaction that appears now;
- one sentence associated with the event;
- a present trigger rather than the original memory.

Instead of:

"Tell me everything that happened."

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Ask:

"What is the smallest part that feels workable today?"

A person may use the private title:

"The incident at the old house."

The practitioner does not require the details.

Possible Set-Up

"Even though the title of this event brings pressure to my chest, I do not need to enter the whole memory. I will work only with this small amount and remain aware of the room."

11.12 Distance Techniques

Psychological distance can reduce emotional intensity.

The person may imagine:

- the event on a distant screen;
- a closed book containing the memory;
- a photograph rather than a moving scene;
- watching from outside the room;
- reducing the image's size;
- removing sound temporarily;
- using a neutral title;
- observing only the beginning of the story.

Example:

"Even though seeing the scene on a distant screen still makes me uneasy, I remain here in the present and can turn the screen off."

The distance should be increased when activation rises and reduced only with the person's agreement.

11.13 Content-Free Trauma Work

The person may wish to keep the event private.

A content-free assessment can include:

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- a private title;
- present intensity;
- bodily location;
- image, sound, or sensation;
- whether the event feels near or distant;
- the person's ability to stop.

Example

"There is an event I do not want to describe. When I think of its title, I feel pressure in my throat at an intensity of six."

Set-Up

"Even though this private event brings pressure to my throat, I acknowledge my reaction. I do not need to describe the event, and I can stop at any time."

Reminder Phrases

"This private event."

"This pressure in my throat."

"Only the title."

"I remain in this room."

Content-free language protects privacy, but it does not make every trauma suitable for self-treatment. Severe dissociation or overwhelming activation still requires specialist care.

11.14 Pendulum of Attention

Rather than remaining continuously focused on distress, attention can alternate between:

1. the difficult sensation;
2. a neutral or supportive present-moment experience.

For example:

"Notice the tightness in your chest for a moment."

Then:

"Notice your feet against the floor."

Then:

"Return only to the outer edge of the memory."

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Then:

"Look at the window and identify its shape."

This alternating structure helps prevent the memory from occupying the whole field of awareness.

The person should not be required to return to the distress if stability has not been restored.

11.15 Dissociation

Dissociation involves a disruption or disconnection in awareness, memory, identity, emotion, bodily experience, or perception of the environment. Trauma-related presentations may include emotional numbing, depersonalization, de-realization, memory gaps, or a sense of being absent from the present situation.

NICE includes dissociation among the possible symptoms of PTSD and recommends that dissociation be addressed as a potential barrier to engagement with trauma-focused treatment. It also advises against supported computerized trauma-focused CBT where severe dissociative symptoms or risk of harm are present.

Possible observable signs include:

- staring without responding;
- sudden reduction in speech;
- appearing confused about the room;
- reporting that the surroundings seem unreal;
- feeling outside the body;
- numbness;
- losing track of time;
- difficulty remembering part of the session;
- abrupt changes in voice, posture, or awareness;
- inability to feel the feet or hands.

These signs are not sufficient for diagnosis. They indicate that the session should slow down and that further assessment may be needed.

11.16 What to Do When Dissociation Appears

Stop memory-focused tapping.

Use simple orientation:

“Please look around the room.”

“Can you tell me where you are?”

“What is today’s date?”

“Can you name three objects you see?”

“Can you feel the chair beneath you?”

“Would you like to stand, move, or take a pause?”

Use concrete rather than abstract spiritual language.

Avoid:

“Leave your body and surrender.”

“Go deeper into the memory.”

“Allow the energy to take over.”

“Do not resist what is happening.”

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These statements may increase disconnection.

If orientation does not return promptly, if the person cannot maintain safety, or if severe dissociation is recurrent, end the exercise and arrange appropriate clinical support.

11.17 Grounding Through the Senses

A simple sensory orientation can include:

- five things seen;
- four physical contact points felt;
- three sounds heard;
- two neutral scents noticed;
- one taste or sip of water.

The numbers are not essential. The purpose is to restore contact with the current environment.

The person may also:

- press both feet against the floor;
- hold a cool object;
- name the current city;
- describe the color of the walls;
- move the hands slowly;
- look towards the exit;
- speak to a trusted person.

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Grounding should not be painful or startling. Do not use ice, shouting, or forceful physical contact without clear clinical justification and consent.

11.18 Flashbacks

During a flashback, a person may experience aspects of the trauma as though they are occurring in the present.

Possible responses include:

- vivid images;
- bodily sensations;
- sounds or smells;
- terror;
- confusion about time;
- defensive movements;
- inability to recognize current safety.

NICE recommends that established PTSD treatments teach strategies for managing arousal and flashbacks and include safety planning.

During a flashback:

1. stop trauma-focused tapping;
2. reduce verbal complexity;
3. identify the current location;
4. avoid unexpected touch;
5. help the person notice present sensory information;
6. assess immediate risk;
7. obtain additional help when needed.

A grounding phrase may be:

“This is a memory response. I am in this room now.”

A spiritual phrase may be:

“O Allah, help me recognize the present and remain connected with what is around me.”

Do not argue with the person or demand that the experience stops immediately.

11.19 Trauma Memory Versus Trauma Story

A trauma memory is not necessarily organized like an ordinary narrative. A person may recall:

- isolated images;
- body sensations;
- sounds;
- fragments;
- emotions;
- meanings;
- gaps.

The practitioner should not pressure the person to create a complete chronological account during SEFT.

Avoid leading questions:

“Was the door locked?”

“Did the perpetrator say this?”

“Did this happen because of your father?”

"Is your body remembering an event your mind has forgotten?"

Such questions may introduce unverified material.

Use neutral inquiry:

"What do you notice?"

"Is that an image, thought, sensation, or memory?"

"How certain are you about that detail?"

"Would you prefer not to explore it?"

SEFT should never be used to recover supposed hidden memories or establish legal facts.

11.20 Avoiding False Certainty

During emotional work, images or impressions may emerge. Their presence does not prove that they are accurate historical memories.

The practitioner should avoid saying:

"Your body never lies."

"This image proves the event happened exactly this way."

"Tapping has released a suppressed memory."

A safer response is:

"An image has appeared during the exercise. We do not need to decide immediately what it represents."

Where legal, safeguarding, or forensic issues are involved, careful professional procedures are necessary.

11.21 A Gentle Present-Trigger Protocol

The following protocol is designed for a moderate present trigger—not for detailed processing of a severe traumatic event.

Target

A loud door closing causes a fear response.

Present Situation

The person is currently in a safe office and remains oriented.

Initial Rating

Fear: 6/10.

Set-Up

While tapping the side of the hand:

"Even though the sound of the door activated fear in my body, I am in this office now. I can see the window, feel the chair, and stop whenever I choose."

Tapping Round

Top of head:

"This present fear response."

Eyebrow:

"My body reacted to the sound."

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Side of eye:

"Part of me expected danger."

Under eye:

"I can see the room around me."

Under nose:

"That sound has ended."

Chin:

"I am noticing the reaction from the present."

Collarbone:

"I do not need to enter the whole memory."

Under arm:

"I can feel my feet and the chair."

Top of head:

"I remain here and can choose what happens next."

Reassessment

Ask:

- Is the person oriented?
- Has fear decreased, increased, or changed?
- Did a detailed memory emerge?
- Does the person wish to stop?
- Is specialist trauma support available?

If the event begins to feel present rather than remembered, stop and ground.

11.22 Working with a Trauma Title

A person may assign a short, neutral title:

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"The motorway accident."

"The hospital night."

"The incident at school."

"The argument in the kitchen."

The title allows assessment without detailed disclosure.

Set-Up

"Even though the title 'the hospital night' brings a strong reaction, I do not need to open the entire memory. I will remain with only the title and the feeling of my feet on the floor."

The person can then tap with:

"Only the title."

"This reaction to the words."

"I am here now."

The exercise should stop if the title immediately activates overwhelming sensory memory.

11.23 Complex Trauma

Complex trauma commonly involves prolonged or repeated experiences from which escape was difficult or impossible, such as repeated childhood abuse, torture, slavery, prolonged domestic violence, or other sustained forms of severe threat.

NICE describes complex PTSD as including the core features of PTSD together with pervasive difficulties in emotion regulation, negative self-beliefs involving shame or defeat, and persistent relationship difficulties.

A person with complex trauma may struggle with:

- rapid emotional shifts;
- chronic shame;
- self-harm;
- unstable relationships;
- fear of closeness;
- fear of abandonment;
- dissociation;
- difficulty identifying needs;
- distrust of authority;
- spiritual conflict;
- an unstable sense of self.

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A single tapping script is unlikely to address this pattern.

Treatment may require:

- additional time to establish trust;
- careful coordination;
- management of risk and comorbid conditions;
- skills for emotional regulation;
- work with relationships and identity;
- structured trauma-focused intervention;
- continuing support after treatment.

NICE specifically recommends considering safety and stability in the person's circumstances and addressing barriers such as dissociation, substance misuse, emotional dysregulation, interpersonal difficulties, and negative self-perception.

11.24 Why Rapid Relief Requires Caution

A person may report that a severe memory has moved from 10 to 0 after one tapping round.

This report should be respected, but several possibilities should be considered:

- genuine short-term reduction in distress;
- emotional exhaustion;
- temporary distraction;
- desire to satisfy the practitioner;
- emotional numbing;
- dissociative disconnection;
- change in one aspect while others remain;
- difficulty accessing the memory at that moment.

Do not immediately declare:

“The trauma is completely cleared.”

Instead ask:

“When you return gently to the original trigger, what do you notice?”

“Do you feel calm, numb, distant, or disconnected?”

“Can you still feel your body and the room?”

“How does this affect daily functioning?”

Change should be evaluated over time and across real-life triggers.

11.25 Trauma Processing Is Not Emotional Flooding

Exposure-based PTSD treatments do involve approaching memories and avoided situations, but they do so gradually and within a structured therapeutic protocol. Prolonged Exposure, for example, involves assessment, preparation, a planned hierarchy, repeated practice, and guidance from a trained provider.

Emotional flooding means pushing a person into overwhelming activation without adequate structure or control.

Statements such as:

“You must fully relive it for tapping to work.”

“Stay with the worst moment until the intensity breaks.”

are not appropriate general SEFT instructions.

Intensity is not evidence of therapeutic quality.

11.26 Avoiding Mechanical Exposure

Repeatedly tapping while reciting the same trauma statement may become mechanical or overwhelming.

After each short round, ask:

- Is the target still the same?
- Has the emotion changed?
- Is the person still present?
- Has the body become numb?
- Does the person wish to continue?
- Is another method now more appropriate?

Do not continue simply because the planned number of rounds has not been completed.

11.27 Spiritual Trauma and Religious Injury

Trauma may affect a person's spiritual life. In some cases, religious language, institutions, leaders, or beliefs may have formed part of the traumatic experience.

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Examples include:

- abuse by a religious authority;
- forced religious practices;
- threats of divine punishment;
- spiritual justification of domestic violence;
- exclusion from a faith community;
- pressure to forgive a perpetrator;
- belief that trauma resulted from weak faith;
- feeling abandoned by God.

A traditional SEFT prayer may be comforting for one person and highly activating for another.

Ask:

"Does spiritual language feel supportive, difficult, or both?"

"Are there words you do not want included?"

"Would neutral language feel safer today?"

Spiritually Neutral Statement

"Even though religious language currently activates fear and anger; I do not need to use it in this exercise. I can work with safety, dignity, and choice."

Spiritual-Struggle Statement

"Even though part of me feels abandoned by God, I acknowledge this painful struggle without condemning myself."

The practitioner should not defend the institution, debate theology, or pressure the person to return to religious practice.

11.28 Moral Injury

Some traumatic experiences involve a perceived violation of deeply held moral values.

A person may feel:

- guilt about what they did;
- shame about failing to act;
- betrayal by an authority;
- anger about being forced into an impossible decision;
- loss of trust in institutions;
- spiritual condemnation.

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Moral injury is not resolved simply by reducing distress. It may require:

- careful examination of responsibility;
- acknowledgement of coercive circumstances;
- apology or restitution where possible;
- grief;
- ethical reflection;
- spiritual care;
- self-forgiveness or forgiveness;
- community accountability.

A possible SEFT statement is:

"Even though I feel deep guilt about what happened, I am willing to examine my responsibility accurately rather than either excuse everything or condemn myself without limit."

A spiritual version is:

"O Allah, help me face what I regret, repair what can be repaired, and seek mercy without avoiding responsibility."

11.29 Shame After Trauma

Trauma survivors may blame themselves for:

- freezing;
- not escaping;
- not fighting;
- remaining in a relationship;
- returning to the perpetrator;
- not reporting;
- experiencing bodily reactions;
- feeling numb;
- surviving when others did not.

A shame-sensitive statement might be:

"Even though I judge myself for how my body responded, I acknowledge that the reaction occurred under threat. I am willing to examine it with compassion rather than using hindsight to punish myself."

The practitioner should not make unqualified conclusions about why the person responded in a particular way. The aim is to reduce harsh self-condemnation while preserving factual and ethical accuracy.

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11.30 Anger and Revenge

Trauma-related anger may involve strong urges for revenge.

A session should distinguish:

- emotional intensity;
- violent imagery;
- intention;
- planning;
- access to the person or weapon;
- protective factors;
- ability to delay action.

Where there is a credible risk of harm, tapping is not sufficient. Immediate risk-management procedures are required.

A low-risk regulation statement may be:

"Even though I feel intense anger and want the person to understand the harm caused, I will not take action while highly activated. I can seek justice through safe and lawful means."

11.31 Trauma-Informed Online Sessions

Remote work presents additional risks because the practitioner is not physically present.

Before beginning, confirm:

- the person's current location;
- a telephone number;
- privacy;
- whether the perpetrator or another person is nearby;
- access to emergency support;
- what will happen if the connection fails;
- whether the person can remain safely in the location afterwards;
- whether driving or another unsafe activity is occurring.

Do not begin detailed trauma work when:

- the person lacks privacy;
- the connection is unstable;
- the person is in a public setting;
- the practitioner cannot identify the location;
- no emergency plan is available;
- the person is severely dissociative;
- imminent risk is suspected.

Online self-help resources for PTSD can provide education and support, but the U.S. National Center for PTSD states that PTSD is a serious condition that often requires professional evaluation and that self-help tools are not substitutes for needed care.

11.32 Group SEFT and Trauma

Group demonstrations should not invite participants to activate their most traumatic memories.

Avoid instructions such as:

"Think of the worst thing that ever happened to you."

"Everyone rate their childhood trauma."

"Tell the group what came up."

A safer group target is:

"Notice mild tension associated with being here today."

Participants should be told:

- not to disclose private details;
- to select a low-intensity target;
- that they may observe without participating;
- that they may keep their eyes open;
- that they may leave or ground themselves;
- where individual support is available.

A facilitator cannot assume responsibility for processing multiple severe trauma reactions simultaneously.

11.33 Children and Young People

Trauma work with children requires developmental adaptation, safeguarding awareness, consent or assent processes, family-system consideration, and specialist competence.

NICE recommends trauma-focused CBT delivered by trained practitioners for children and young people with clinically important PTSD symptoms and sets out age-specific recommendations. EMDR is considered for some children and young people where trauma-focused CBT is not effective or cannot be engaged with.

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A general SEFT practitioner should not attempt to treat child PTSD independently.

Low-intensity supportive tapping might use language such as:

"My body feels jumpy when I hear that sound, and I can look around and see that I am here now."

The adult should not touch the child without appropriate consent, safeguarding procedures, and professional justification.

11.34 Practitioner Emotional Reactions

Trauma work can affect the practitioner.

Possible reactions include:

- sadness;
- anger;
- helplessness;
- intrusive imagery;
- over identification;
- desire to rescue;
- emotional withdrawal;

- fear of asking about risk;
- excessive certainty;
- boundary changes.

A practitioner who needs the person to improve quickly may unintentionally pressure them.

Supervision should examine:

- the practitioner's emotional response;
- clinical decisions;
- risk;
- boundaries;
- competence;
- spiritual assumptions;
- documentation;
- referral needs.

A powerful personal experience with SEFT does not replace clinical supervision.

11.35 Documentation

A professional trauma-related note should include:

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- consent;
- current safety;
- selected target;
- level of detail discussed;
- distress and orientation ratings;
- tapping procedure;
- grounding methods;
- signs of dissociation;
- risk assessment;
- referrals;
- follow-up plan.

Use observational language:

"Participant became quiet, looked away, and reported that the room felt distant."

Avoid:

"The person's energy left the body."

The first statement records what was observed and reported. The second assigns an unverified explanation.

11.36 Indicators to Stop Trauma-Related SEFT

Stop the exercise when the person:

- asks to stop;
- becomes disoriented;
- cannot identify the current location;
- experiences severe dissociation;
- reports loss of control;
- becomes increasingly panicked;
- develops violent or suicidal intent;
- experiences a medical emergency;
- becomes intoxicated;
- cannot maintain basic communication;
- is exposed to immediate danger;
- loses the ability to distinguish memory from present reality;
- becomes physically exhausted.

Stopping is an active clinical decision, not a failure.

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11.37 Referral Indicators

Specialist assessment is indicated when there is:

- suspected PTSD or complex PTSD;
- severe or repeated trauma;
- childhood sexual or physical abuse;
- torture or trafficking;
- continuing domestic violence;
- serious dissociation;
- recurrent flashbacks;
- severe nightmares;
- self-harm;
- suicidal thinking;
- homicidal thinking;
- psychosis or mania;
- substance dependence;
- marked functional impairment;
- inability to maintain safety;
- significant safeguarding concerns.

NIMH advises seeking professional help when post-trauma symptoms do not improve or interfere with daily functioning.

11.38 Evidence and Professional Position

Research on tapping for trauma-related symptoms has produced encouraging reports, but important questions remain concerning:

- study quality;
- sample size;
- independent replication;
- comparison with established treatment;
- practitioner effects;
- protocol consistency;
- long-term outcomes;
- the additional contribution of spiritual content.

NICE's current guideline, last reviewed in April 2025 without a change to its recommendations, continues to recommend trauma-focused CBT and EMDR while retaining EFT as a research question.

SEFT should therefore be described as:

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- a possible adjunct;
- a grounding or regulation exercise;
- a culturally adaptable practice;
- an area requiring stronger research.

It should not be described as:

- a proven cure for PTSD;
- a replacement for trauma-focused psychotherapy;
- a technique safe for every trauma survivor;
- a method that permanently clears trauma in minutes;
- proof of an energetic or spiritual cause of symptoms.

11.39 Trauma-Informed SEFT Checklist

Area	Question
Safety	Is the danger past, ongoing, or uncertain?
Consent	Does the person understand and voluntarily agree?
Competence	Is this work within the practitioner's training and legal scope?
Orientation	Can the person remain aware of the current time and place?

Regulation	Can the person move attention away from the memory?
Dissociation	Are there signs of numbness, unreality, memory gaps, or disconnection?
Target	Is the selected aspect small and manageable?
Privacy	Can the person keep details private if desired?
Spirituality	Is spiritual language supportive and freely chosen?
Stopping	Is there a clear stop signal?
Risk	Is there self-harm, violence, abuse, or medical danger?
Support	Is help available after the session?
Follow-up	Is specialist assessment or treatment required?

11.40 Chapter Summary

Trauma-informed SEFT begins with safety, consent, trust, choice, collaboration, and respect for the person's pace. It is not defined merely by using gentler tapping words.

Trauma-informed practice must be distinguished from trauma-focused treatment. A practitioner can teach grounding without being qualified to process traumatic memories. Severe trauma, PTSD, complex PTSD, dissociation, self-harm, continuing abuse, and major functional impairment require appropriately trained professionals.

Stabilization includes present-moment orientation, safety planning, emotional regulation, support, and the ability to stop. Trauma material should be approached in small portions, using distance and content-free methods where appropriate. The person does not need to provide a complete account.

Dissociation requires particular caution. When the person becomes disconnected from the body, room, memory, or identity, memory-focused tapping should stop and present orientation should become the priority.

Spiritual language must be consensual. It should not pressure surrender, forgiveness, reconciliation, or silence. Religious beliefs may be a source of strength, but religious language or institutions may also form part of the trauma.

Current clinical guidance supports structured trauma-focused CBT and EMDR for PTSD. EFT remains an area for further research rather than an established first-line treatment. SEFT is therefore best positioned as a carefully bounded complementary practice.

The central principle is:

The goal is not to make the person relive more. The goal is to help the person experience greater safety, choice, present awareness, and access to appropriate care.

Stabilization Worksheet

Part A: Present Safety

The event is:
☐ Completely in the past
☐ Ongoing
☐ Uncertain

I am physically safe at this moment:
☐ Yes
☐ No
☐ Unsure

Immediate protective action needed:

Part B: Orientation

My current location is:

Today's date is:

Three things I can see are:

Two physical contact points I can feel are:

One sound I can hear is:

Part C: Capacity

Current distress:
_____ /10

Connection with the present:
_____ /10

I can move attention away from the issue:
☐ Yes
☐ No
☐ Unsure

My stop signal is:

Part D: Small Target

The private title of the event or trigger is:

The smallest workable aspect is:

The bodily sensation is:

Part E: Stabilizing Set-Up

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"Even though _____
I am in _____
on _____
I do not need to enter the whole memory.
I can stop by _____
and return attention to _____

Part F: After the Exercise

Current distress:
_____ /10

Connection with the present:
_____ /10

I feel:
☐ Grounded
☐ Activated
☐ Numb
☐ Confused

☐ Exhausted
☐ Another response: _____

Support I will contact is:

Professional referral needed:
☐ Yes
☐ No
☐ Unsure

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Chapter 12

What Research Suggests and What It Does Not Establish

Research on Emotional Freedom Techniques has expanded substantially, but the scientific status of the method remains debated. Some randomized trials, systematic reviews, and meta-analyses report meaningful reductions in anxiety, depression, stress, pain, and post-traumatic symptoms. Other scholars have questioned the quality of the underlying trials, reliance on self-reported outcomes, use of inactive control groups, researcher allegiance, inconsistent diagnostic procedures, and the strength of claims made from relatively small evidence bases.

Research on Spiritual Emotional Freedom Technique is less developed. Most SEFT studies have been conducted in Indonesia or neighboring settings, often within nursing, education, rehabilitation, or community-health contexts. The literature includes pre–post studies, quasi-experimental designs, small controlled trials, and locally published reviews. These studies may provide useful preliminary information, but they do not yet establish SEFT as a standard treatment for a diagnosed psychological or medical disorder.

Scientific balance requires two errors to be avoided.

The first error is to dismiss every reported improvement simply because the technique appears unusual.

The second is to treat every positive study as final proof that the intervention works through the mechanism claimed by its proponents.

A responsible conclusion lies between these extremes:

EFT has a growing but contested evidence base. SEFT has a smaller and less methodologically mature evidence base. Both require stronger independent research before broad clinical claims can be justified.

12.1 What Counts as Evidence?

Not every source provides the same level of scientific support.

A personal story may show that one person experienced a change. It cannot establish that the method caused the change or that similar people will obtain the same result.

A pre–post study may show that participants improved after treatment. It cannot determine confidently whether the improvement resulted from:

- the intervention;
- passage of time;

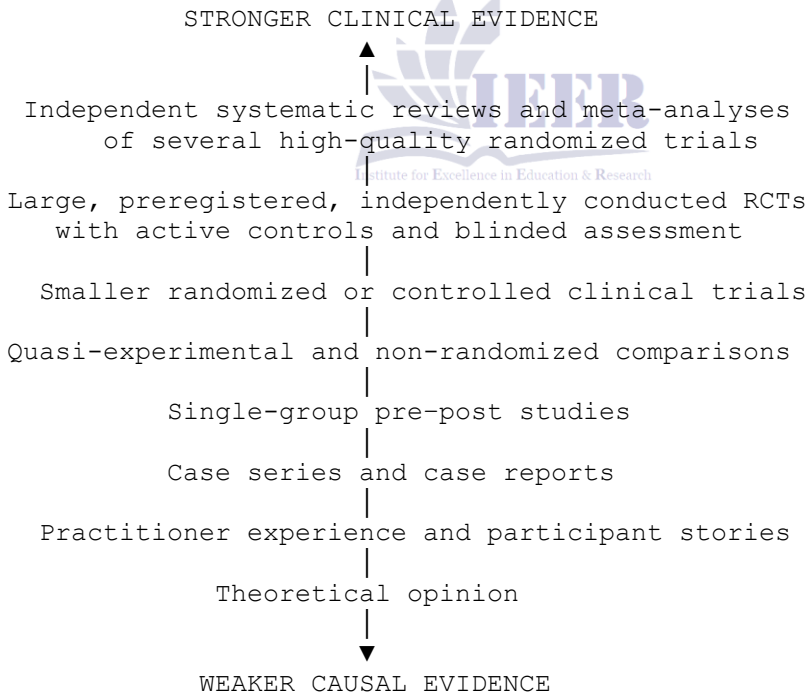
- natural recovery;
- expectation;
- attention from the practitioner;
- another treatment;
- repeated measurement;
- changes in life circumstances.

A controlled trial provides a comparison group, making causal interpretation stronger. A randomized trial reduces but does not eliminate, the risk that the groups differed systematically before treatment.

A systematic review attempts to identify and evaluate all relevant studies according to predefined methods. A meta-analysis statistically combines results when studies are sufficiently comparable.

However, a meta-analysis is not automatically strong evidence. A pooled result cannot correct serious weaknesses in the studies being combined. A meta-analysis of small, biased, highly variable trials may produce a precise-looking number without providing a trustworthy clinical conclusion.

12.2 An Evidence Hierarchy for SEFT



Note. Evidence from lower levels may generate hypotheses and inform future research. It should not be discarded, but it should not be treated as equivalent to replicated randomized evidence.

12.3 Efficacy, Effectiveness, and Clinical Utility

Three terms should be distinguished.

Efficacy

Efficacy asks:

"Can the intervention produce benefit under controlled research conditions?"

An efficacy trial may use carefully trained practitioners, strict inclusion criteria, a manualized protocol, and close monitoring.

Effectiveness

Effectiveness asks:

"Does the intervention help in ordinary practice?"

Participants in routine settings may have several diagnoses, family difficulties, inconsistent attendance, medical conditions, and limited access to specialist care.

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Clinical Utility

Clinical utility asks:

"Is the intervention practical, acceptable, safe, affordable, culturally appropriate, and useful alongside available services?"

An intervention can show efficacy while remaining difficult to implement. It may also be acceptable and inexpensive but lack sufficient evidence of clinical benefit.

Research on SEFT should address all three questions rather than assuming that popularity proves effectiveness.

12.4 Statistical Significance Is Not Clinical Significance

A statistically significant result indicates that the observed difference would be relatively unlikely under a specified null hypothesis. It does not automatically show that the difference is large, durable, meaningful to patients, or superior to an established treatment.

A statistically significant reduction of one point on a forty-point anxiety scale may have little practical importance. Conversely, a moderate improvement in sleep, functioning, or ability to

attend medical treatment may be clinically meaningful even when complete symptom elimination does not occur.

Researchers should therefore report:

- mean differences;
- standardized effect sizes;
- confidence intervals;
- reliable change;
- clinically significant change;
- remission or recovery rates;
- functional outcomes;
- adverse events;
- follow-up results.

A statement such as:

"The result was significant at $p < .05$" is not sufficient by itself.

12.5 Understanding Effect Size

An effect size describes the magnitude of a difference or change.

A standardized mean difference expresses change in units of standard deviation. Conventional descriptions sometimes refer to values near 0.20 as small, 0.50 as moderate, and 0.80 as large. These categories are only rough guides. The clinical meaning depends on the disorder, outcome, measurement quality, comparator, study design, and consequences of treatment.

Very large effects should be examined carefully, especially when they arise from:

- small samples;
- self-reported outcomes;
- wait-list comparisons;
- un-blinded assessment;
- selective publication;
- participants recruited because they expect the intervention to help.

Large effects may represent genuine benefit. They may also be inflated by bias or sampling variation.

12.6 Confidence Intervals

A confidence interval communicates uncertainty around an estimated effect.

A narrow interval suggests greater precision. A wide interval suggests that the true effect could vary substantially.

Researchers and readers should not focus only on whether the interval crosses zero. They should ask:

- Is the estimated range clinically important?
- Does it include trivial as well as substantial effects?
- Is the sample large enough?
- Was the analysis planned in advance?
- Are the outcome data complete?

Certainty cannot be judged from the point estimate alone.

12.7 Current Evidence for Anxiety

A 2025 systematic review examined randomized trials of EFT for anxiety symptoms. The review concluded that EFT appeared promising as a complementary intervention, but the included studies differed considerably in populations, session numbers, control conditions, measures, and treatment procedures. The authors called for better-standardized and higher-quality research. Available direct comparisons did not demonstrate clear superiority over cognitive behavioral therapy.

Earlier meta-analytic work also reported larger pre–post anxiety reductions in EFT groups than in combined control groups. These findings contributed to interest in the method, but many included studies involved elevated anxiety symptoms rather than independently diagnosed anxiety disorders.

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The appropriate conclusion is:

EFT may reduce anxiety symptoms in some populations, but the evidence does not establish it as superior to well-supported anxiety treatments.

For SEFT, studies have examined examination anxiety, preoperative anxiety, illness-related anxiety, and distress in rehabilitation settings. The diversity and generally small scale of these studies make it difficult to determine whether benefits result from tapping, prayer, attention, relaxation, group support, expectancy, or their combination.

12.8 Current Evidence for Depression

A 2024 meta-analysis reported favorable effects of EFT on depressive symptoms. However, the studies differed in participant characteristics, delivery format, intervention length, severity, and comparator conditions. The authors recommended further investigation of long-term outcomes and broader clinical applications.

Earlier reviews also reported large reductions in depressive symptoms, but some combined randomized and non-randomized studies, which weakens causal certainty.

The distinction between **depressive symptoms** and **major depressive disorder** is important. A reduction on a self-report depression scale does not necessarily demonstrate remission from a clinically diagnosed disorder.

Research should include:

- structured diagnostic assessment;
- severity classification;
- suicide-risk monitoring;
- active treatment comparisons;
- longer follow-up;
- functional outcomes;
- reporting of concurrent medication and psychotherapy.

SEFT should not be presented as a replacement for established depression treatment, particularly where severe depression, psychosis, self-neglect, or suicidal thinking is present.

12.9 Current Evidence for PTSD

The PTSD literature contains some of the strongest claims made for EFT and some of the strongest criticism.

A 2025 systematic review and meta-analysis included 13 studies involving 621 participants. It reported large improvements in PTSD symptoms compared with baseline and controls, together with reductions in anxiety and depression that were maintained for up to three months.

A 2023 review of six randomized studies also reported large effects when EFT was compared with wait-list, no-treatment, or usual-care controls. Differences were smaller when EFT was compared with active treatments such as CBT, narrative exposure therapy, or EMDR. The review acknowledged modest study numbers, small samples, possible publication bias, reliance on self-report, and incomplete reporting of treatment fidelity.

A published commentary challenged the interpretation of that review. The critics noted substantial overlap with an earlier meta-analysis, inconsistent inclusion of eligible studies, reliance on self-reported PTSD symptoms without diagnostic interviews, and possible conflicts connected with commercial EFT training. They argued that the evidence had been described more confidently than the methods justified.

NICE reviewed its PTSD guideline in April 2025 and found no new evidence requiring a change. EFT remains listed as a research recommendation rather than a recommended first-line treatment.

The professional conclusion is therefore:

EFT has produced promising PTSD findings, but the evidence remains contested and has not displaced established trauma-focused treatments in major clinical guidance.

12.10 Current Evidence for Stress and Physiological Outcomes

Several studies have investigated stress ratings and biological markers.

A 2012 randomized study reported a larger reduction in salivary cortisol following a single EFT session than after supportive interviewing or no treatment. A later replication reported a substantial cortisol reduction, although the physiological findings were not mirrored consistently by subjective distress measures.

These studies are relevant because cortisol provides an outcome beyond self-report. However, cortisol is influenced by:

- time of day;
- sleep;
- medication;
- food;
- physical activity;
- acute illness;
- menstrual and hormonal factors;
- sample collection procedures;
- ordinary biological variation.

A change in cortisol does not prove that tapping corrected a meridian disturbance or identify the mechanism responsible for improvement.

Biomarkers may show that a physiological change occurred. They do not by themselves show why it occurred.

12.11 Current Evidence for Pain and Medical Populations

Recent trials have reported improvements in pain severity, pain interference, pain catastrophizing, and distress in selected medical populations. Findings have been reported in chronic pain, cancer care, postoperative recovery, and inflammatory conditions.

Such studies should be interpreted according to the exact outcome.

If emotional distress decreases, the conclusion should be:

“The intervention was associated with reduced emotional distress.”

It should not become:

“The disease was healed.”

If pain intensity decreases, the study still does not establish:

- tissue repair;
- reduced tumor burden;
- altered disease progression;
- removal of inflammation;
- permanent recovery.

EFT may have value as an adjunctive method for pain-related distress or coping, while SEFT may additionally provide culturally meaningful spiritual support. Neither should replace medical investigation or treatment.

12.12 Current Evidence for SEFT

SEFT research is considerably smaller than the broader EFT literature.

Published SEFT studies have reported changes in outcomes such as:

- anxiety;
- depression;
- pain;
- stress;
- sleep;
- hopelessness;
- spiritual well-being;
- quality of life;
- emotional regulation;
- illness-related distress.

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Systematic reviews focusing on SEFT have generally described favorable trends, including within cancer care and psychological well-being. However, many reviews draw upon small local studies, heterogeneous interventions, non-randomized designs, and journals with limited international methodological scrutiny.

The studies often differ in:

- number of tapping points;
- prayer wording;
- session length;
- practitioner qualifications;
- individual or group format;
- comparison condition;
- participant diagnosis;
- outcome measures.

This variability makes replication difficult.

A study labelled “SEFT” may involve:

- short tapping with Islamic prayer;
- an extended eighteen-point sequence;
- tapping combined with *dhikr*;
- group psychoeducation;
- family support;
- virtual-reality content;
- routine nursing care.

These interventions should not be treated as identical merely because they share the SEFT name.

12.13 Why Control Groups Matter

The control group determines what question a study can answer.

No-Treatment Control

This comparison asks:

"Did participants receiving SEFT improve more than participants receiving nothing?"

It does not separate the specific effects of SEFT from attention, expectation, repeated contact, hope, and structured activity.

Wait-List Control

Participants know that they will receive treatment later. This controls partly for time but may increase disappointment or reduce expectation in the comparison group.

Treatment as Usual

This comparison asks whether SEFT adds benefit to ordinary care. The meaning depends on what ordinary care actually includes.

Attention Control

Participants receive equivalent time and human attention without the active SEFT procedure.

Active Psychological Control

SEFT is compared with another credible intervention such as relaxation, supportive counselling, CBT, mindfulness, or stress-management education.

Sham-Tapping Control

Participants complete a similar procedure using non-prescribed points or altered instructions.

Sham controls are difficult to design. Tapping anybody location may provide sensory stimulation, rhythm, attention, expectancy, or relaxation. A poorly designed sham condition may therefore be either too active or insufficiently believable.

Component or Factorial Trial

This design can compare:

1. tapping alone;
2. prayer alone;
3. combined tapping and prayer;
4. a credible active control.

This is particularly important for SEFT because it can show whether the spiritual component contributes benefit beyond EFT and whether the combination is more useful than either element alone.

12.14 Placebo and Expectancy

The word *placebo* is sometimes used as though it means that nothing happened. This is inaccurate.

Expectancy, therapeutic attention, ritual, trust, and the meaning of treatment can influence subjective experience and behavior. In psychotherapy, these factors are not equivalent to an inert sugar tablet. They form part of the interpersonal and contextual environment.

The relevant scientific question is not:

“Is the improvement real or placebo?”

The better question is:

“Which components produced the improvement, and how much did each contribute?”

Possible contributors include:

- expectation of benefit;
- attention from a supportive practitioner;
- emotional disclosure;
- exposure to a feared memory;
- cognitive reframing;
- self-acceptance;
- repetitive movement;
- tactile stimulation;
- breathing changes;

- prayer;
- spiritual meaning;
- group support;
- behavioral action after the session.

A credible active control is necessary to separate these effects.

12.15 Researcher and Practitioner Allegiance

Researchers may have strong positive or negative expectations about an intervention.

Allegiance can influence:

- study questions;
- control-group selection;
- therapist enthusiasm;
- outcome interpretation;
- publication decisions;
- language used in conclusions.

Several prominent EFT reviews have included authors who conduct EFT research, write books, provide training, or are affiliated with EFT organizations. A 2025 mechanisms review disclosed that its author writes books and provides training on the subject.

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This does not make the research invalid. It means that:

- conflicts should be disclosed fully;
- independent replication is essential;
- data analysis should be transparent;
- conclusions should remain proportionate;
- negative findings should be publishable.

Critics can also have strong theoretical commitments. Scientific evaluation should focus on methods and data rather than the reputation of either side.

12.16 Blinding Challenges

In psychotherapy research, practitioners usually know which intervention they are delivering. Participants often recognize the treatment they receive. Complete double-blinding is therefore rarely possible.

However, several forms of blinding remain achievable:

- assessors can be unaware of treatment allocation;
- statisticians can analyses coded groups;
- researchers conducting diagnostic interviews can remain blinded;

- outcome hypotheses can be preregistered;
- treatment fidelity can be assessed independently.

The inability to blind the therapist does not remove the need to reduce bias in every other part of the study.

When the outcome is entirely self-reported and participants know that they are receiving a novel intervention expected to work, expectancy may influence scores. Blinded clinician-rated assessment and behavioral outcomes therefore strengthen the evidence.

12.17 Self-Report and Objective Outcomes

Self-report is necessary because pain, fear, sadness, shame, spiritual distress, and quality of life contain subjective experiences.

The problem is not the use of self-report. The problem is relying on self-report alone.

A stronger study may combine:

- validated self-report measures;
- blinded diagnostic interviews;
- behavioral tasks;
- attendance or adherence;
- sleep monitoring;
- work or academic functioning;
- medication use;
- physiological measures;
- follow-up assessment.

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For PTSD research, critics have specifically noted that self-reported symptoms should not be treated as equivalent to a structured diagnostic assessment.

12.18 Small Samples and Unstable Effects

Small studies may fail to detect real effects. They may also produce exaggerated effects by chance.

Problems associated with small samples include:

- imprecise estimates;
- poor balance between groups;
- limited ability to assess adverse events;
- unstable subgroup findings;
- inability to adjust for important variables;
- increased influence of participant dropout.

A trial involving twenty or thirty participants may be valuable as a pilot. It should not be presented as definitive confirmation.

12.19 Attrition and Missing Data

Participants may leave a study because:

- the intervention is ineffective;
- symptoms worsen;
- the procedure feels uncomfortable;
- attendance is difficult;
- treatment takes too much time;
- another therapy is started;
- life circumstances change.

If only participants who complete treatment are analyzed, results may appear more favorable.

Researchers should report:

- numbers screened;
- numbers randomized;
- numbers completing each stage;
- reasons for withdrawal;
- adverse experiences;
- intention-to-treat analysis;
- handling of missing data.

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CONSORT 2025 provides updated standards for clear and transparent reporting of randomized trials.

12.20 Selective Reporting and Preregistration

A study may measure ten outcomes and report only the two that became significant.

Preregistration reduces this problem by recording in advance:

- the primary outcome;
- secondary outcomes;
- sample size;
- analysis plan;
- exclusion rules;
- follow-up schedule.

Changes may still be made, but they should be identified transparently.

SEFT trials should be registered before participant recruitment in an appropriate clinical-trial registry.

12.21 Publication Bias

Positive studies are more likely to be submitted, accepted, discussed, and included in reviews than studies reporting no effect.

Publication bias can create the appearance that almost every trial is favorable.

Warning signs include:

- many small positive studies;
- very few neutral or negative studies;
- unusually large effects;
- lack of registered protocols;
- repeated studies by the same research group;
- absence of unpublished dissertations or completed trials.

A 2023 EFT PTSD review acknowledged that publication bias may have occurred and that the number and size of available studies were limited.

Negative SEFT findings are scientifically important. They help identify:

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- unsuitable populations;
- ineffective protocols;
- unnecessary components;
- realistic limits;
- possible harms.

12.22 Heterogeneity

Heterogeneity refers to differences between studies.

SEFT studies may differ in:

- age;
- diagnosis;
- cultural setting;
- spiritual orientation;
- practitioner training;
- number of sessions;
- tapping sequence;
- prayer content;
- outcome measure;
- comparison condition;

- follow-up period.

When studies are highly different, a pooled average may not describe any one actual intervention.

Researchers should explain whether variation is:

- clinical;
- methodological;
- statistical.

Subgroup analyses should be planned in advance and interpreted cautiously, particularly when only a few studies are available.

12.23 Risk of Bias

Cochrane's revised Risk of Bias tool evaluates a specific result from a randomized trial across areas including randomization, deviations from intended intervention, missing data, outcome measurement, and selective reporting.

A study may be randomized and still have substantial risk of bias.

For example:

- allocation may not be concealed;
- groups may differ at baseline;
- participants may receive unequal additional care;
- dropout may differ between groups;
- assessors may know treatment allocation;
- analyses may differ from the registered plan.

Researchers should not use the word *randomized* as a complete guarantee of quality.

12.24 Adverse Events and Safety

Tapping is physically low-risk for many people, but psychological safety cannot be assumed.

Possible adverse experiences include:

- temporary distress;
- activation of traumatic memories;
- panic;
- shame;
- dissociation;
- disappointment;
- delayed medical treatment;
- pressure to disclose;

- spiritual guilt;
- harmful advice about medication;
- financial exploitation.

Some EFT reviews report few or no adverse events, but lack of reported harm is not the same as systematic evidence of safety. Trials may fail to ask about adverse experiences or report them clearly. A 2023 review claimed no adverse events across a large body of EFT studies while also acknowledging broader limitations in the available trials. Every trial should define, monitor, and report adverse events.

12.25 What May Explain Improvement?

No single mechanism has been established.

Theories can be organized into several categories.

Focused Exposure

The person deliberately attends to a distressing memory, image, sensation, or feared situation instead of avoiding it completely. Repeated contact under tolerable conditions may reduce reactivity or change the meaning of the trigger.

Cognitive Reappraisal

Set-up and integration statements may help the person develop a less catastrophic or self-condemning interpretation.

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For example:

“This rejection proves I am worthless”

may become:

“This was one painful outcome, but it does not define my entire value.”

Affect Labelling

Naming an emotion may help organize an otherwise vague internal experience.

Self-Acceptance and Compassion

The set-up statement may reduce secondary shame and self-criticism.

Attentional Shifting

Tapping requires attention to move between language, body points, rhythm, sensation, and the emotional target. This may interrupt repetitive rumination.

Somatosensory Stimulation

Tapping produces repetitive tactile input. The specific contribution of prescribed acu-points remains debated.

A 2018 review of comparative studies concluded that acu-point stimulation contributed beyond other components. A later mechanisms review reached a similar conclusion but acknowledged small samples, researcher allegiance, weaknesses in randomization, and differences between sham and active instructions.

Autonomic Regulation

Rhythmic movement, slower pacing, attention, expectation, and supportive interaction may influence arousal.

Therapeutic Alliance

Feeling heard and supported may contribute significantly to change.

Expectancy and Ritual

A clear procedure can create hope, predictability, and a sense of personal participation.

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Spiritual Coping

Prayer may provide meaning, hope, trust, connection, humility, or acceptance. For SEFT, these effects may be central.

Memory Reconsolidation

Some authors propose that activating a memory while introducing a contradictory experience of safety allows the memory to be updated. This is a plausible research hypothesis, but existing evidence does not establish that SEFT reliably produces memory reconsolidation or that reconsolidation explains its clinical outcomes.

12.26 Energy and Meridian Explanations

Traditional EFT and SEFT describe emotional problems partly through disruptions in an energy system or meridian network.

These ideas are historically important to the method, but they remain scientifically controversial. There is no standard clinical instrument that:

- measures an EFT emotional-energy blockage;
- identifies its exact location;
- demonstrates that tapping removed it;
- predicts who will respond.

Modern mechanisms papers have attempted to reinterpret tapping through neural, electrochemical, connective-tissue, and physiological processes. These proposals should be treated as developing models rather than confirmed explanations. The 2025 mechanisms review itself states that precise mechanisms remain under investigation.

A professional author should therefore write:

"Tapping may influence emotional and physiological regulation through several interacting mechanisms."

Not:

"Science has proven that tapping unblocks the body's energy meridians."

12.27 Biomarkers Do Not Prove Mechanism

Cortisol, heart-rate variability, blood pressure, brain imaging, immune markers, and gene-expression measures can enrich research.

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However:

- an association is not a causal pathway;
- a pre–post change may reflect many influences;
- small biomarker samples are unstable;
- multiple testing increases false-positive risk;
- biological significance may differ from statistical significance.

A mechanisms review correctly notes that biomarker changes are signs accompanying improvement rather than complete explanations of how tapping works.

12.28 What the Evidence Currently Supports

Current evidence permits several cautious statements.

Reasonable Statements

"EFT has shown promising reductions in some psychological symptoms."

"Several trials and reviews report improvement in anxiety, depression, stress, pain, and trauma-related symptoms."

"EFT may be considered a complementary intervention in some settings."

"SEFT may be culturally and spiritually meaningful for individuals who want prayer integrated into emotional-regulation practice."

"More rigorous, independent research is needed."

Statements Not Yet Justified

"SEFT is scientifically proven to cure anxiety, depression, PTSD, cancer, or chronic pain."

"Tapping is superior to CBT, EMDR, medication, or trauma-focused therapy."

"Prayer multiplies the effect of tapping."

"Tapping corrects a measured energy blockage."

"Immediate subjective relief proves permanent recovery."

"SEFT is safe for everyone."

"No adverse effects occur."

"A positive biomarker proves that the disease has improved."

12.29 A Balanced Evidence Classification

Area	Present interpretation
General stress and situational anxiety	Promising for short-term symptom regulation
Diagnosed anxiety disorders	Preliminary to moderate evidence; not established as superior to standard care
Depressive symptoms	Promising, but diagnostic and methodological limitations remain
PTSD symptoms	Positive meta-analytic findings, but substantial methodological controversy and no major first-line guideline endorsement
Pain-related distress	Promising adjunctive findings in selected populations
Medical disease outcomes	Insufficient evidence that tapping changes disease progression
SEFT spiritual component	Insufficient component evidence
Energy-meridian mechanism	Not scientifically established
Safety	Probably low physical risk in ordinary use; psychological and indirect harms require better reporting
Long-term outcomes	Inadequately studied for many conditions

Children and complex trauma	Requires specialist caution and stronger research

12.30 Priorities for Future SEFT Research

Future SEFT studies should include the following features.

1. A Clear Intervention Manual

Researchers should specify:

- tapping points;
- number of taps;
- sequence;
- set-up wording;
- prayer wording;
- spiritual concepts;
- session duration;
- practitioner qualifications;
- home practice;
- modifications.

2. Preregistration

The trial protocol and analysis plan should be registered before recruitment.

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3. Adequate Sample Size

Sample size should be based on a justified power analysis rather than convenience alone.

4. Appropriate Randomization

Random sequence generation and allocation concealment should be described.

5. Credible Active Controls

Useful comparison groups may include:

- supportive counselling;
- relaxation;
- CBT-based stress management;
- prayer alone;
- EFT without spiritual language;
- sham tapping.

6. Blinded Assessment

Independent assessors should remain unaware of group allocation where possible.

7. Validated Outcomes

Primary and secondary outcomes should be identified in advance.

8. Diagnostic Accuracy

Clinical disorders should be assessed through appropriate diagnostic procedures rather than self-report scores alone.

9. Treatment Fidelity

Independent raters should confirm that the intended intervention was delivered.

10. Adverse-Event Monitoring

Researchers should ask directly about worsening symptoms, distress, dissociation, treatment delay, and spiritual discomfort.

11. Longer Follow-Up

Assessment should continue beyond immediate post-treatment measurement.

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12. Independent Replication

Studies should be conducted by teams without commercial or training interests in SEFT.

13. Cultural and Religious Diversity

SEFT should be tested across different faith traditions, levels of religious commitment, languages, and secular populations.

14. Transparent Reporting

Randomized trials should follow CONSORT 2025 reporting standards.

12.31 A Proposed Factorial SEFT Trial

One of the most important unanswered questions is whether spiritual integration adds benefit beyond standard EFT. A four-group randomized trial could compare:

Group	Intervention
Group 1	Standard EFT tapping with neutral acceptance language
Group 2	Prayer and spiritual reflection without tapping
Group 3	Full SEFT combining tapping and spiritual language

Group 4	Credible active stress-management comparison

All groups should receive:

- equal session time;
- equivalent practitioner attention;
- similar expectations;
- standardized manuals;
- blinded outcome assessment.

This design could answer:

- Does tapping add benefit beyond prayer?
- Does prayer add benefit beyond tapping?
- Is the combination superior?
- Are effects moderated by religious commitment?
- Does forced spiritual language reduce benefit?
- Which intervention is more acceptable?

Without such studies, statements about a spiritual amplifying effect remain theoretical.

12.32 Qualitative Research

Quantitative scores cannot explain the full experience of SEFT.

Qualitative interviews can explore:

- how participants understand tapping;
- whether prayer feels authentic;
- how surrender is interpreted;
- whether the method supports or conflicts with faith;
- which words feel coercive;
- whether improvement affects daily behavior;
- why some people do not benefit;
- whether spiritual guilt increases.

Researchers should include negative and mixed experiences rather than interviewing only highly satisfied participants.

12.33 Implementation Research

Even an effective intervention may fail when introduced without appropriate preparation.

Implementation research should examine:

- practitioner training;

- supervision;
- cost;
- cultural adaptation;
- delivery in hospitals or universities;
- online versus face-to-face format;
- group versus individual sessions;
- integration with existing services;
- referral systems;
- safeguarding.

SEFT should not be introduced into a healthcare setting only because it is inexpensive or easy to demonstrate. Institutional use requires evidence, governance, consent, risk management, and professional accountability.

12.34 Research Ethics

SEFT studies should not recruit vulnerable people through exaggerated promises.

Consent documents should state that:

- the intervention is complementary;
- benefit is uncertain;
- participation is voluntary;
- treatment may be stopped;
- spiritual language can be declined;
- usual care will not be withdrawn improperly;
- medical or psychological treatment should continue;
- adverse experiences can be reported.

Participants in control groups should not be denied necessary care.

12.35 Researcher Language

Research conclusions should match the design.

Single-Group Study

Appropriate:

“Symptoms decreased following the intervention.”

Inappropriate:

“SEFT caused the improvement.”

Non-Randomized Comparison

Appropriate:

"The SEFT group showed greater improvement, but group differences and confounding cannot be excluded."

Small Randomized Pilot

Appropriate:

"The findings support feasibility and justify a larger trial."

Inappropriate:

"The therapy has been proven effective."

Meta-Analysis of Heterogeneous Small Trials

Appropriate:

"The pooled estimate suggests benefit, but certainty is limited by study quality and heterogeneity."

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Inappropriate:

"The treatment is conclusively established."

12.36 How Practitioners Should Use Research

Practitioners do not need to become statisticians, but they should be able to ask basic questions.

Before repeating a research claim, ask:

1. Was the study randomized?
2. How many participants were included?
3. Was there an active control group?
4. Were assessors blinded?
5. Was the outcome self-reported?
6. Was the disorder formally diagnosed?
7. How many participants withdrew?
8. Were adverse events measured?
9. Was the protocol registered?
10. Was the study independently replicated?

11. Did the authors have financial or professional interests?
12. Was the improvement clinically meaningful?
13. How long did it last?
14. Does the conclusion apply to SEFT or only to EFT?

An abstract stating that a result was significant should not be converted into a therapeutic guarantee.

12.37 Evidence-Informed Practice

Evidence-informed practice combines:

- best available research;
- professional competence;
- the person's values and preferences;
- cultural and spiritual context;
- clinical judgment;
- available resources;
- ethical and legal standards.

Research is one element, not the only element.

However, values and experience cannot be used to ignore reliable evidence or substitute for necessary treatment.

A person may value SEFT deeply and still require:

- medication;
- trauma-focused therapy;
- medical investigation;
- rehabilitation;
- safeguarding;
- crisis intervention.

12.38 Chapter Summary

Research on EFT has grown and includes randomized trials, systematic reviews, meta-analyses, biomarker studies, and component investigations. Several studies report improvements in anxiety, depression, stress, pain, and post-traumatic symptoms.

These findings are promising, but confidence is limited by small samples, heterogeneous protocols, self-reported outcomes, inactive control conditions, short follow-up, incomplete safety reporting, possible publication bias, and researcher allegiance.

Recent PTSD meta-analyses report substantial effects, while independent critics argue that some reviews overstate the strength and independence of the evidence. NICE continues to treat EFT for adult PTSD as a research question rather than a recommended first-line treatment.

SEFT has a smaller evidence base. Its distinctive spiritual component has not been isolated adequately from tapping, therapeutic attention, expectation, or prayer alone. Claims that spirituality multiplies tapping outcomes therefore remain unproven.

Mechanisms such as exposure, cognitive reappraisal, affect labelling, self-acceptance, tactile stimulation, autonomic regulation, expectancy, spiritual coping, and memory updating may all contribute. No single mechanism has been confirmed, and meridian-energy explanations remain scientifically unestablished.

The scientifically responsible position is neither rejection nor promotion.

It is disciplined uncertainty:

SEFT may be useful for some people as a complementary emotional and spiritual practice. Its benefits, limitations, mechanisms, safety, and appropriate clinical role must continue to be tested through transparent, independent, and methodologically rigorous research.

Critical Appraisal Worksheet

Study Identification

Title:

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Authors and year:

Journal:

Study Design

☐ Randomized controlled trial
☐ Non-randomized controlled study
☐ Single-group pre–post study
☐ Case report
☐ Systematic review
☐ Meta-analysis

☐ Qualitative study
☐ Other

Participants

Sample size: _____

Diagnosis or problem:

How was it assessed?

Intervention

Was the SEFT protocol described fully?
☐ Yes ☐ No ☐ Partly

Number of sessions:

Spiritual wording:

Practitioner training:

Comparison

☐ No treatment
☐ Wait-list
☐ Treatment as usual
☐ Attention control
☐ Active treatment
☐ Sham tapping
☐ No control group

Outcomes

Primary outcome:

Self-report, observer-rated, behavioral, or biological:

Follow-up duration:

Quality Questions

Was the trial preregistered?
☐ Yes ☐ No ☐ Unclear

Was allocation concealed?
☐ Yes ☐ No ☐ Unclear

Were assessors blinded?
☐ Yes ☐ No ☐ Unclear

Was attrition reported?
☐ Yes ☐ No

Were adverse events reported?
☐ Yes ☐ No

Were conflicts of interest disclosed?
☐ Yes ☐ No

Interpretation

What did the study actually find?

What does it not establish?

Is the conclusion stronger than the design permits?

Can the findings be generalized to SEFT?

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Chapter 13

Ethics, Professional Competence, and Spiritual Sensitivity

A technique does not become ethical merely because it is intended to help. Ethical practice depends on how the intervention is described, who delivers it, whether the person has meaningful choice, how privacy is protected, and whether the practitioner recognizes the limits of their training and authority.

SEFT creates several distinctive ethical responsibilities because it brings together emotional intervention, physical tapping, personal disclosure, and spiritual language. The practitioner may be perceived not only as a helper but also as someone with psychological, healing, or religious authority. This position can increase trust, but it can also increase the risk of dependency, coercion, exaggerated claims, and blurred boundaries.

Professional ethics frameworks consistently emphasize competence, informed consent, privacy, appropriate relationships, accurate records, respect for dignity, and protection from exploitation. The APA Ethics Code includes dedicated standards concerning competence, human relationships, privacy, confidentiality, and informed consent. EFT International's code similarly applies to practitioners' relationships with clients, trainees, colleagues, organizations, and the public.

The central ethical principle of SEFT is:

The practitioner must use the method in a way that protects the person's autonomy, dignity, safety, beliefs, privacy, and access to appropriate care.

13.1 Ethics Is More Than Following Rules

Professional codes provide important standards, but no code can predict every clinical situation. Ethical practice also requires judgment.

A practitioner may need to consider:

- whether the intervention is appropriate;
- whether personal competence is sufficient;
- whether spiritual language creates support or pressure;
- whether confidentiality can be maintained;
- whether another relationship creates a conflict;
- whether the person requires medical or psychological treatment;
- whether the practitioner's own beliefs are influencing the session;
- whether continuing is likely to help or harm.

Ethics is therefore an active process of reflection, consultation, documentation, and accountability.

A practitioner should not ask only:

"Am I technically allowed to do this?"

A stronger question is:

"Is this action respectful, proportionate, transparent, and in the person's best interests?"

13.2 The Ethical Position of SEFT

SEFT may be used in several settings:

- self-help education;
- psychological support;
- counselling;
- coaching;
- healthcare;
- rehabilitation;
- spiritual care;
- community program;
- research;
- professional training.

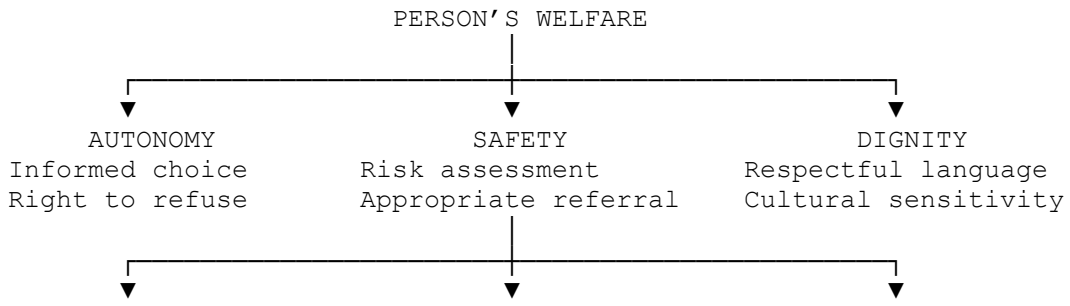
The ethical requirements differ according to the setting.

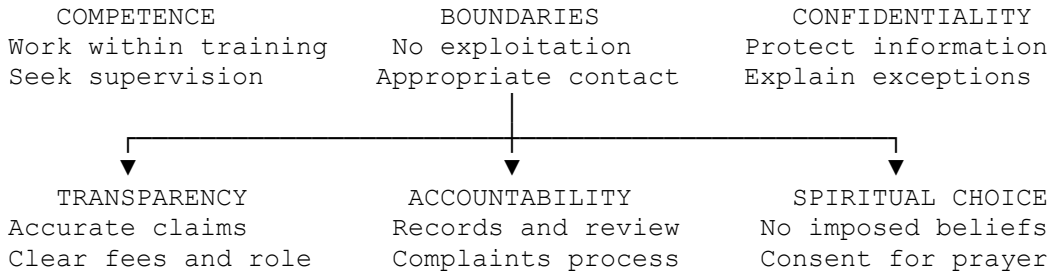
A psychologist using SEFT within psychotherapy has responsibilities defined by psychological ethics, licensing rules, clinical competence, documentation, and treatment standards. A nurse using brief tapping for procedure-related anxiety remains responsible to nursing standards and the medical treatment plan. A coach or spiritual-care provider must not present themselves as diagnosing or treating mental disorders unless separately qualified and legally authorized.

The label *SEFT practitioner* does not replace the professional requirements attached to the person's actual role.

Figure 13

The Ethical Foundations of SEFT Practice





These principles are interdependent. Informed consent is not meaningful when the practitioner exaggerates benefits, hides limitations, or presents spiritual participation as compulsory.

13.3 Scope of Practice

Scope of practice refers to the activities a practitioner is trained, competent, professionally recognized, and legally permitted to perform.

A practitioner should define:

- their foundational profession;
- SEFT education and supervision;
- clinical populations they can work with;
- problems they are competent to address;
- situations requiring referral;
- whether they provide therapy, coaching, education, or spiritual support;
- the limits of their legal authority.

EFT International's ethics and accreditation materials emphasize working within competence, maintaining professional standards, completing ongoing development, participating in mentoring, and following a defined code of conduct. Its internal accreditation is an organizational credential rather than a government license to practice psychology, medicine, counselling, or another regulated profession.

Ethical Role Description

A practitioner might state:

"I am a registered psychologist who integrates SEFT as an adjunctive emotional-regulation method within psychological practice."

Or:

"I provide educational SEFT sessions for ordinary stress. I do not diagnose or treat mental disorders."

Or:

"I provide spiritual-care support and can incorporate tapping when requested. This is not psychotherapy or medical treatment."

The description should allow the person to understand what service is actually being offered.

13.4 Certification Is Not the Same as Clinical Licensure

Completion of a tapping course may indicate that the person attended training in the technique. It does not automatically establish competence in:

- psychiatric diagnosis;
- suicide-risk assessment;
- trauma treatment;
- domestic-violence intervention;
- child safeguarding;
- medication management;
- rehabilitation;
- treatment of medical illness.

EFT International itself distinguishes levels of training and requires practice, case work, assessment, mentoring, continuing development, and adherence to its ethics code for accreditation.

A practitioner should not use an SEFT certificate to imply possession of qualifications that have not been earned.

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Misleading Description

"Certified trauma healer and clinical psychologist"

when the person has neither recognized psychology training nor regulated clinical credentials.

Clearer Description

"Certified SEFT practitioner offering non-clinical stress-management education."

Titles must comply with the laws and professional regulations of the jurisdiction in which the service is delivered.

13.5 Boundaries of Competence

Professional competence includes more than knowledge of tapping points.

It requires the ability to:

- assess suitability;
- recognize risk;

- explain limitations;
- select appropriate language;
- manage emotional activation;
- identify dissociation;
- protect confidentiality;
- recognize medical warning signs;
- refer appropriately;
- document accurately;
- use spirituality without coercion.

The APA Ethics Code states that psychologists provide services within the boundaries of competence established through education, training, supervised experience, consultation, study, or professional experience.

Competence must be matched to the person and problem. A practitioner may be competent to use SEFT for ordinary presentation anxiety but not for severe childhood trauma, psychosis, suicidal depression, or medically unexplained neurological symptoms.

13.6 Cultural and Spiritual Competence

Spiritual competence does not mean becoming an authority on every religion. It involves:

- recognizing that spirituality may matter;
- asking rather than assuming;
- understanding the limits of one's knowledge;
- respecting nonreligious positions;
- recognizing spiritual struggle;
- consulting appropriate specialists;
- avoiding religious interpretation outside one's role.

APA materials concerning spiritual diversity emphasize awareness, sensitivity, and skill in working with religious and spiritual differences. They also note that spiritual issues can be relevant in therapy when incorporated competently and according to the client's worldview.

A Muslim practitioner should not assume that every Muslim participant wants identical prayer language. A secular practitioner should not dismiss spiritual meaning merely because it falls outside their personal worldview.

13.7 Informed Consent as an Ongoing Process

Consent is not complete when a person signs a form at the beginning of treatment. It must continue throughout the professional relationship.

Before SEFT begins, the person should understand:

- what SEFT involves;

- the practitioner's role and qualifications;
- the proposed purpose;
- likely session structure;
- uncertainty concerning outcomes;
- possible emotional discomfort;
- alternative options;
- confidentiality and its limits;
- fees and cancellation arrangements;
- record-keeping;
- online-practice arrangements;
- the right to refuse spiritual language;
- the right to stop tapping.

Professional ethics frameworks treat informed consent and self-determination as central obligations.

Plain-Language Consent Statement

"SEFT combines focused attention, verbal statements, and gentle self-tapping. Some people experience reduced distress, while others experience limited or no change. Emotional material may become more active. You can pause or stop at any time. This method does not replace medical or psychological treatment."

Consent should be understandable. Technical language should not be used to discourage questions.

13.8 Consent for Every New Level of Work

A person who agrees to learn basic tapping has not necessarily consented to:

- trauma-memory processing;
- discussion of childhood experiences;
- spiritual prayer;
- practitioner touch;
- audio or video recording;
- public demonstration;
- group disclosure;
- research participation;
- use of their story in training;
- contact with relatives or healthcare providers.

Additional consent is required when the nature of the work changes.

The practitioner should say:

"You agreed to work with current stress. A past event has now emerged. Would you like to remain with the present issue, discuss the earlier event, or stop?"

Silence should not be treated as permission.

13.9 Spiritual Consent

Spiritual language should be explicitly discussed rather than assumed from a name, dress, family background, nationality, or religious community.

Ask:

“Would you like prayer included?”

“Which words are personally meaningful?”

“Are there religious expressions that you do not want used?”

“Would you prefer secular acceptance language?”

A person may consent to prayer in one session and decline it in another. Spiritual preference can change depending on the issue.

Ethical Spiritual Integration

“O Allah, help me face this fear with steadiness.”

Coercive Spiritual Integration

“Repeat this prayer because the method cannot work without faith.”

Spirituality becomes unethical when it is used to override choice.

13.10 Consent for Touch

Self-tapping should be the normal procedure.

When touch is considered, the practitioner should explain:

- why it is proposed;
- which exact area is involved;
- how long contact would last;
- available alternatives;
- the person’s right to decline.

Consent should be obtained immediately before the contact, not assumed from a general treatment form.

The person's body language should also be observed. Withdrawal, freezing, nervous laughter, silence, or visible discomfort require the practitioner to stop and check rather than continue.

A simple rule is:

Demonstrate on yourself and allow the person to tap themselves.

13.11 Power in the Practitioner Relationship

The practitioner may have power because of:

- professional status;
- specialist knowledge;
- age;
- institutional authority;
- religious role;
- social status;
- control over assessment or certification;
- the participant's vulnerability;
- claims of healing ability.

This power exists even when the practitioner behaves warmly.

The person may agree because they fear disappointing the practitioner, appearing spiritually weak, losing access to care, or being judged as resistant.

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The practitioner should reduce unnecessary power differences by:

- inviting questions;
- acknowledging uncertainty;
- offering alternatives;
- avoiding pressure;
- welcoming disagreement;
- allowing refusal without penalty;
- avoiding claims of exclusive knowledge;
- encouraging independent medical or psychological advice.

13.12 Avoiding Spiritual Authority Claims

SEFT practitioners should not claim that they:

- possess a unique healing gift;
- can identify divine punishment;
- know the spiritual cause of an illness;
- can measure the person's faith;
- can guarantee forgiveness;

- can speak on behalf of God;
- know that a relationship must continue or end;
- know that suffering was spiritually chosen.

The practitioner may support the person's spiritual reflection but should not replace a religious scholar, chaplain, theologian, or faith leader when specialized spiritual guidance is needed.

Even when the practitioner has religious education, theological guidance and psychological treatment should be clearly distinguished.

13.13 Boundaries

Professional boundaries define the limits of the relationship. They protect the participant from exploitation and help maintain clarity, consistency, and safety.

BACP's current ethical framework emphasizes competence, clear communication, privacy, accurate records, appropriate relationships, and respect for the boundaries between professional work and activities outside that work.

Boundaries include:

- session time;
- location;
- communication outside sessions;
- physical contact;
- fees;
- gifts;
- social-media connections;
- personal disclosure;
- transport;
- home visits;
- dual relationships;
- emergency contact;
- ending the professional relationship.

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A boundary is not emotional coldness. It provides a dependable structure.

13.14 Dual and Multiple Relationships

A dual relationship exists when the practitioner has another significant role with the participant.

Examples include:

- teacher and therapist;
- supervisor and therapist;
- employer and counsellor;

- religious leader and clinician;
- family friend and practitioner;
- examiner and treatment provider;
- business partner and client.

Some overlap may be unavoidable in small communities. The ethical question is whether the additional role:

- impairs objectivity;
- increases pressure;
- creates exploitation;
- affects confidentiality;
- makes refusal difficult;
- creates conflicting responsibilities.

A university supervisor should be cautious about providing emotionally intensive SEFT therapy to a student whose academic evaluation they control. The student may not feel free to decline or disclose dissatisfaction.

13.15 Sexual and Romantic Boundaries

Sexual or romantic involvement with current clients is incompatible with an ethical helping relationship. Emotional vulnerability and power imbalance make meaningful consent difficult.

Flirtation, sexualized comments, unnecessary intimate touch, and suggestive spiritual language are also inappropriate.

The use of tapping points on the upper body requires particular care. The practitioner must not use the technique to normalize touch that would otherwise be professionally unacceptable.

13.16 Gifts, Favoritism, and Dependency

Gifts may carry cultural meanings of gratitude, respect, hospitality, or obligation. The practitioner should consider:

- value;
- timing;
- cultural meaning;
- possible expectation;
- impact on boundaries;
- institutional policy.

An inexpensive culturally customary gift may differ from money, jewelry, expensive travel, or a gift offered in exchange for preferential treatment.

The practitioner should avoid creating dependency through statements such as:

"Only I understand your energy."

"You should not work with another therapist."

"You need weekly sessions indefinitely."

An ethical practitioner supports increasing autonomy and appropriate collaboration.

13.17 Confidentiality

Confidentiality allows people to discuss difficult experiences with greater trust. Professional frameworks treat protection of private information as a central responsibility. BACP describes confidentiality as foundational to the therapeutic relationship and requires practitioners to explain when private information may be communicated to others.

Before treatment begins, explain:

- what records will be kept;
- who can access them;
- how information is stored;
- whether supervision is used;
- circumstances requiring disclosure;
- legal limitations;
- procedures for online communication;
- how long records are retained.

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Confidentiality should not be promised as absolute when the law or professional duty may require action concerning imminent danger, abuse, safeguarding, or a court order.

13.18 Confidentiality in Spiritual Communities

A person may be known to the practitioner through a mosque, church, temple, community organization, school, or professional network.

The practitioner should not:

- disclose attendance;
- request prayer publicly without permission;
- discuss the person with community leaders;
- reveal a diagnosis;
- use the case in a sermon or workshop;
- assume family members may be informed.

Even well-intentioned spiritual support can violate privacy.

The person should decide whether a religious adviser or family member becomes involved unless a lawful safeguarding exception applies.

13.19 Confidentiality in Groups

Group facilitators should explain that they can request confidentiality but cannot guarantee the behavior of every participant.

Group members should be instructed not to:

- repeat personal stories;
- identify participants publicly;
- photograph or record without consent;
- share screenshots;
- discuss another member's emotional response.

Participants should not be required to disclose their tapping target. Private phrases or neutral labels may be used.

13.20 Supervision and Confidentiality

Supervision is essential for maintaining ethical and effective practice. BACP defines it as a specialized form of professional mentoring that supports standards, quality, learning, sustainability, and resilience.

Clients should be informed that cases may be discussed in supervision. Identifying information should be limited whenever possible.

Supervision should not become informal storytelling or curiosity about dramatic cases.

13.21 Record-Keeping

Records should be accurate, relevant, secure, and proportionate.

A SEFT note may include:

- date and duration;
- consent;
- presenting concern;
- selected target;
- distress rating;
- wording used;
- tapping sequence;
- participant response;
- risk assessment;
- referral;

- follow-up plan.

Avoid speculative statements:

"The client released inherited negative energy."

Use:

"The participant reported reduced chest pressure from 7 to 4."

Professional frameworks emphasize keeping accurate and appropriate records and documenting what has been agreed with the client.

13.22 Digital Records and Online Practice

Online SEFT may involve video platforms, email, messaging, cloud storage, payment systems, and digital forms.

The practitioner should consider:

- platform security;
- password protection;
- recording settings;
- privacy of the participant's location;
- data-storage jurisdiction;
- access by third-party services;
- emergency procedures;
- identity verification;
- interruptions;
- connection failure.

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Online work also requires clear boundaries concerning who initiates the call, what happens if contact is lost, and how emergency assistance will be obtained. BACP's online and telephone competence framework identifies boundaries, contracting, communication, privacy, and technological competence as important areas of online practice.

A practitioner should not record online sessions by default. Recording requires a specific purpose, explicit consent, secure storage, and a clear deletion policy.

13.23 Social Media

Social media can blur professional and personal roles.

A practitioner should decide in advance:

- whether client friend requests will be accepted;

- whether private messages are used for clinical contact;
- how comments on public posts are handled;
- whether testimonials are shared;
- whether educational content could identify clients;
- whether the practitioner searches for clients online.

The practitioner should not respond publicly in a way that confirms someone is a client.

Case examples used in posts should be fictionalized or used only with carefully considered consent. Changing a name alone may not prevent recognition.

13.24 Public Demonstrations

SEFT is often demonstrated at workshops, conferences, training sessions, and online events.

A public demonstration can create pressure because the participant may feel unable to stop in front of an audience.

Before proceeding:

- explain the purpose;
- select a low-intensity concern;
- avoid severe trauma;
- protect privacy;
- establish a stop signal;
- prohibit recording unless separately agreed;
- provide follow-up support;
- clarify that declining will have no negative consequence.

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The facilitator should not seek dramatic emotional release for entertainment or marketing.

13.25 Testimonials and Case Stories

Testimonials can create unrealistic expectations because people who experience strong benefit may be more likely to provide them than those who experience no change or worsening.

A testimonial should not be used to imply:

- guaranteed results;
- medical cure;
- permanent healing;
- universal effectiveness;
- superiority over established treatment.

Even when a participant gives permission, the practitioner should consider whether public disclosure may later cause embarrassment or affect relationships, employment, or reputation.

Consent given during gratitude or emotional dependence may not reflect the person's future interests.

13.26 Responsible Advertising

Advertising should describe:

- qualifications accurately;
- services clearly;
- evidence proportionately;
- fees transparently;
- limitations honestly.

Appropriate Claim

"SEFT is a spiritually adaptable tapping-based practice that some people use for emotional regulation."

Inappropriate Claim

"Scientifically proven to cure trauma, depression, diabetes, cancer, and chronic pain."

The EFT International code applies to interactions with the public as well as clients and trainees, reinforcing the practitioner's responsibility for professional communication.

The absence of evidence for a claim cannot be corrected by adding phrases such as *energy healing*, *quantum*, *neuroscience-based*, or *clinically proven*.

13.27 Fees and Financial Transparency

Before treatment begins, the person should know:

- the fee;
- session duration;
- payment method;
- cancellation policy;
- refund policy;
- charges for reports or letters;
- expected number of sessions, where possible;
- whether additional products or training will be offered.

The practitioner should avoid:

- hidden fees;
- pressure to purchase packages;
- suggesting that expensive levels are necessary for healing;

- creating fear to increase attendance;
- refusing referral because of financial loss.

A package should not be sold with a guaranteed emotional or medical outcome.

Financial hardship should not be interpreted as lack of commitment.

13.28 Conflicts of Interest

A conflict of interest may arise when the practitioner benefits financially or professionally from a recommendation.

Examples include:

- selling supplements;
- referring exclusively to a business owned by the practitioner;
- receiving commission from training program;
- recommending repeated certification courses;
- using client stories to promote a book;
- recruiting clients into paid research without clear disclosure.

The practitioner should disclose relevant interests and provide alternatives when possible.

13.29 Working with Children and Vulnerable People

Children, people with cognitive impairment, and dependent adults may have reduced ability to understand or refuse an intervention.

The practitioner must consider:

- legal consent;
- the person's assent;
- developmental understanding;
- safeguarding;
- parental or caregiver involvement;
- privacy;
- ability to stop;
- power imbalance.

EFT International's safer-working guidance emphasizes recognizing abuse, neglect, and maltreatment and taking appropriate action to keep children and young people safe.

A child's participation should not be forced merely because a parent requests it.

The practitioner should not ask a child to keep therapy secret from a safe caregiver. At the same time, the child's privacy should be respected within the limits of safeguarding and law.

13.30 Capacity and Supported Decision-Making

A person may have difficulty understanding, remembering, or weighing information because of:

- cognitive impairment;
- acute illness;
- intoxication;
- severe psychiatric disturbance;
- neurological conditions;
- developmental disability.

Capacity should not be assumed absent merely because a person has a diagnosis. Information may need to be simplified, repeated, illustrated, or discussed with an authorized supporter.

When meaningful consent cannot be obtained, the practitioner must follow the applicable legal and professional framework rather than proceeding because the technique appears harmless.

13.31 Referral

Referral is appropriate when:

- risk exceeds the practitioner's competence;
- diagnosis is required;
- symptoms suggest medical illness;
- severe trauma emerges;
- the person needs medication review;
- safeguarding concerns exist;
- progress is absent;
- another treatment has stronger evidence;
- the professional relationship has become unhelpful;
- cultural or spiritual expertise is needed.

Referral should be described as part of good care:

"This concern requires expertise beyond what I can safely provide. I recommend assessment by a qualified trauma practitioner."

It should not be presented as rejection or failure.

13.32 Collaboration with Other Professionals

With consent, collaboration may include:

- physicians;
- psychologists;
- psychiatrists;

- counsellors;
- nurses;
- speech-language therapists;
- social workers;
- occupational therapists;
- religious scholars;
- safeguarding services.

The SEFT practitioner should communicate within their role.

A report might state:

“SEFT was used to support anxiety regulation before rehabilitation exercises.”

It should not state:

“The patient’s energetic cause of paralysis was removed.”

13.33 Supervision, Mentoring, and Continuing Development

Competence is not permanent. It must be maintained.

Continuing development may include:

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- ethics;
- trauma awareness;
- suicide-risk assessment;
- safeguarding;
- cultural competence;
- spiritual diversity;
- medical red flags;
- online practice;
- research literacy;
- data protection;
- professional boundaries.

EFT International requires continuing professional development and mentoring for accredited members, while BACP treats appropriate supervision as a continuing professional responsibility.

Supervision should be used before, not only after, a serious problem occurs.

Useful supervision questions include:

“Am I working beyond competence?”

“Am I pressuring spiritual language?”

"Has the person become dependent?"

"Do I need to refer?"

"Is my personal history affecting my judgment?"

13.34 Practitioner Well-Being and Impairment

A practitioner's emotional or physical condition can affect the quality of care.

Possible warning signs include:

- exhaustion;
- irritability;
- inability to concentrate;
- over identification;
- repeated lateness;
- poor record-keeping;
- boundary violations;
- using clients for emotional support;
- avoiding difficult risk questions;
- feeling indispensable.

BACP's ethical commitments include maintaining sufficient practitioner well-being to sustain the quality of work.

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A practitioner who is impaired should seek supervision, reduce workload, obtain personal treatment, or pause practice when necessary.

Self-tapping should not be treated as the only response to professional impairment.

13.35 Personal Beliefs and Countertransference

The practitioner's own experiences may influence reactions to the client.

Examples include:

- identifying strongly with a survivor;
- disapproving of divorce;
- believing forgiveness is always required;
- feeling threatened by religious doubt;
- wanting to rescue a distressed person;
- judging medication use;
- assuming that spiritual surrender should occur quickly.

The practitioner should examine these reactions rather than inserting them into the session.

A question for supervision is:

"Does this recommendation arise from the person's needs or from my own values and discomfort?"

13.36 Complaints and Accountability

Participants should know:

- the practitioner's professional affiliation;
- how to raise a concern;
- whether an external complaint process exists;
- how records can be requested;
- what happens after a complaint?

EFT International maintains an ethics and professional-conduct structure for consultation, investigation, and adjudication of alleged breaches among its members.

A practitioner should not respond to a complaint with retaliation, spiritual blame, public disclosure, or pressure to withdraw it.

Complaints may reveal:

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- misunderstanding;
- unclear consent;
- boundary failure;
- poor communication;
- actual misconduct;
- weaknesses in organizational procedures.

Accountability includes learning from justified criticism.

13.37 Ethical Decision-Making Framework

When an ethical problem arises, use the following process.

Step 1: Define the Problem

What happened? Who may be affected?

Step 2: Identify Immediate Risk

Is anyone in danger? Is urgent action required?

Step 3: Review Consent and Role

What was agreed? What is the practitioner's actual scope?

Step 4: Consult Standards

Which professional code, law, institutional policy, or safeguarding procedure applies?

Step 5: Examine Personal Bias

Are financial, spiritual, emotional, or professional interests influencing judgment?

Step 6: Consider Options

What actions are available? What are their likely benefits and harms?

Step 7: Seek Consultation

Use supervision, legal consultation, professional bodies, or specialist advice without disclosing unnecessary identifying information.

Step 8: Decide and Document

Record the information considered, consultation obtained, decision made, and rationale.

Step 9: Review the Outcome

Did the action protect the person? Is further follow-up needed?

Table 3

Ethical Warning Signs in SEFT Practice

Warning sign	Ethical concern	Safer response
"SEFT will cure you"	Misrepresentation	Explain possible benefits and uncertainty
Prayer is compulsory	Spiritual coercion	Obtain specific spiritual consent
Practitioner taps intimate areas	Boundary violation	Use self-tapping and non-contact demonstration
Client is told to stop medication	Scope and safety breach	Refer medication decisions to the prescriber
Severe trauma is processed publicly	Privacy and re-traumatization	Use low-intensity targets and private specialist care
Practitioner discourages other therapy	Dependency and isolation	Support coordinated care
Stories are used in advertising	Confidentiality and exploitation	Use fictional examples or carefully evaluated consent

No referral despite deterioration	Competence failure	Seek assessment and specialist care
Expensive packages guarantee healing	Financial exploitation	Use transparent fees without outcome guarantees
Spiritual struggle is called weak faith	Shame and coercion	Validate the struggle and offer appropriate support
Records contain energetic conclusions	Unverifiable documentation	Record observations and reported experiences
Practitioner refuses supervision	Accountability concern	Engage in regular competent supervision

13.38 Professional SEFT Agreement

A written agreement may include:

Practitioner's name and qualifications:

Professional role:

Purpose of SEFT:

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Limits of the service:

Spiritual language preference:
☐ Explicit prayer
☐ Quiet spiritual intention
☐ Secular language
☐ Decided session by session

Touch policy:

Confidentiality and exceptions:

Record-keeping:

Fees and cancellation policy:

Online-session procedure:

Emergency and referral procedure:

Complaints procedure:

Participant's right to stop:

This agreement should support discussion rather than replace it.

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13.39 Chapter Summary

Ethical SEFT practice requires more than technical knowledge. The practitioner must work within competence, describe qualifications accurately, obtain ongoing consent, protect privacy, maintain boundaries, use spiritual language respectfully, and refer when the person's needs exceed the practitioner's role.

An SEFT certificate is not equivalent to professional licensure in psychology, medicine, counselling, nursing, or another regulated field. The practitioner's claims and activities must remain consistent with their actual qualifications and local law.

Spiritual content requires explicit consent. The practitioner must not interpret illness as punishment, measure faith, impose forgiveness, claim divine authority, or use surrender to encourage passivity.

Self-tapping is the preferred physical method. Touch must never be assumed. Particular caution is required with children, vulnerable adults, public demonstrations, online work, groups, and participants with trauma histories.

Confidentiality must be explained honestly, including its legal and safeguarding limits. Records should document what was observed, reported, and done rather than present energy or spiritual interpretations as established facts.

Professional supervision, continuing development, accurate advertising, transparent fees, and a clear complaints procedure strengthen accountability.

The ethical question at the heart of every session is:

"Am I supporting this person's informed choice, dignity, safety, and access to appropriate care or am I using the technique, my position, or spiritual language to exercise control?"

Ethical Practice Checklist

Qualifications and Role

My foundational professional qualification is:

My SEFT education and supervised experience are:

The services I am competent to provide are:

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The services I must not provide are:

Consent

Have I explained:

☐ The procedure
☐ Possible discomfort
☐ Limitations
☐ Alternatives
☐ Right to stop
☐ Confidentiality
☐ Fees
☐ Records
☐ Referral arrangements

Spirituality

Has spiritual consent been obtained?
☐ Yes ☐ No ☐ Not applicable

The person's preferred language is:

Am I introducing any personal spiritual assumption?

Boundaries

Is another relationship present?
☐ Yes ☐ No

Could the person feel pressured to agree?

Is touch necessary?
☐ No
☐ Yes (reason and consent documented)

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Safety and Referral

Is there medical, psychological, trauma, or safeguarding risk?

Is this within my competence?
☐ Yes ☐ No ☐ Uncertain

Consultation or referral required:

Accountability

Supervisor or mentor:

Professional code followed:

Complaints process provided:
☐ Yes ☐ No

Decision and rationale documented:
☐ Yes ☐ No

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Chapter 14

Self-Practice and Guided Practice

SEFT can be used independently for ordinary emotional regulation or facilitated by a trained practitioner. These two forms of practice are related, but they are not interchangeable.

Self-practice is most appropriate when the concern is mild or moderate, the individual can remain oriented to the present, and the issue does not involve immediate danger, severe trauma, suicidal thinking, psychosis, serious dissociation, or an untreated medical problem.

Guided practice may be preferable when:

- the concern is difficult to define;
- distress rises quickly;
- several emotions are active;
- a traumatic memory may be involved;
- spiritual language feels complicated;
- progress has stopped;
- the person needs help distinguishing emotion from practical action;
- risk assessment or referral may be necessary.

The practitioner does not perform SEFT *to* the participant. The practitioner creates a structured environment in which the participant can observe, choose, tap, pray or use secular language, pause, and evaluate the experience.

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The purpose of both self-practice and guided practice is not repeated pursuit of emotional relief. The purpose is to develop greater awareness, flexibility, responsibility, and access to appropriate support.

14.1 When Self-Practice Is Appropriate

Self-practice may be suitable for concerns such as:

- mild nervousness before a meeting;
- ordinary frustration;
- temporary stress;
- difficulty settling after a demanding day;
- disappointment;
- manageable anger;
- preparation for a difficult conversation;
- mild anxiety while waiting for routine information;
- emotional tension associated with an already assessed physical condition;
- difficulty beginning a task.

The person should be able to answer yes to the following questions:

1. Can I remain aware of my surroundings?
2. Can I stop the exercise voluntarily?
3. Is the issue emotionally manageable?
4. Am I physically safe?
5. Am I continuing necessary medical or psychological care?
6. Do I know whom to contact if distress increases?
7. Am I working with one limited aspect rather than my whole life history?

Self-practice is not a test of emotional strength. Choosing not to work alone with a difficult issue is a responsible decision.

14.2 When Not to Practice Alone

Independent tapping should stop or be avoided when the person experiences:

- suicidal thoughts;
- urges to self-harm;
- thoughts of harming another person;
- hallucinations;
- severe confusion;
- loss of contact with reality;
- intense dissociation;
- severe panic that does not settle;
- continuing violence or abuse;
- a medical emergency;
- rapidly worsening physical symptoms;
- inability to perform basic self-care;
- overwhelming traumatic memories;
- intoxication or substance withdrawal.

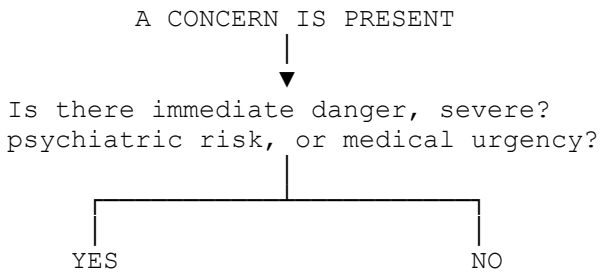
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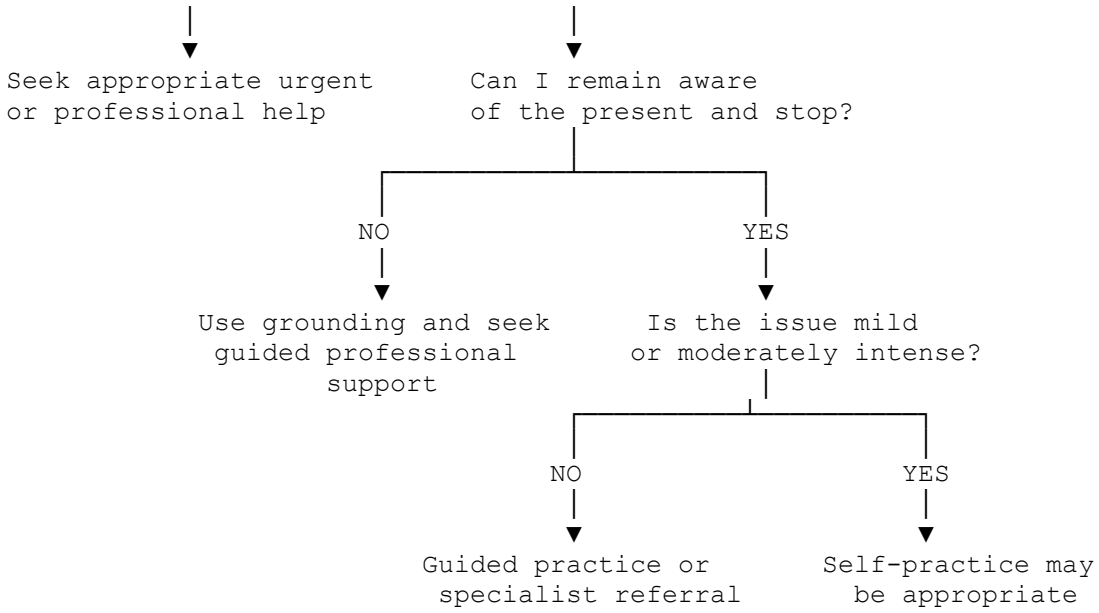
These situations require appropriate professional, medical, safeguarding, or emergency assistance.

A person may use simple grounding while help is being obtained, but SEFT should not become the only response.

Figure 14

Choosing Between Self-Practice and Guided Support





14.3 Preparing for Self-Practice

Before beginning, create a short period in which interruption is unlikely.

The person should:

- sit or stand in a stable position;
- silence unnecessary notifications;
- have water available;
- avoid practicing while driving;
- select a private or sufficiently comfortable environment;
- identify a stop signal;
- decide how long the practice will last;
- choose one specific issue.

A self-practice session does not need to be long. Five to fifteen minutes may be sufficient for a limited concern.

The person should not begin with:

“I will continue until the emotion disappears completely.”

A safer intention is:

“I will practice for ten minutes, observe honestly, and stop if the experience becomes too intense.”

14.4 The Ten-Minute Self-Practice Structure

Minute 1: Orientation

Notice:

- the current location;
- the date;
- the support of the chair;
- both feet on the floor;
- one neutral object in the room.

Minute 2: Select the Target

Complete the sentence:

"The specific concern I am working with is…"

Example:

"The tightness in my chest when I think about tomorrow's meeting."

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Minute 3: Establish the Baseline

Record:

- emotion;
- bodily sensation;
- distress rating;
- main thought;
- desired direction.

Minutes 4–5: Set-Up

Tap the side of the hand and repeat the selected statement three times.

"Even though I feel pressure in my chest when I think about tomorrow's meeting, I acknowledge my anxiety and ask Allah for steadiness and clear expression."

Minutes 6–7: Tapping Round

Use the short sequence with brief reminder phrases.

Minute 8: Pause

Stop tapping. Notice breathing, posture, thoughts, and bodily sensations.

Minute 9: Reassess

Ask:

- What is the intensity now?
- What changed?
- What remains?
- Did another emotion emerge?

Minute 10: Close

Identify one responsible next action.

"I will prepare the first three points for the meeting."

Then return attention fully to the room.

14.5 A Three-Minute Brief Practice

When time is limited, use a shortened structure.

Step 1

Name the present concern:

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"I feel tense about the telephone call."

Step 2

Tap the side of the hand:

"Even though I feel tense, I acknowledge the reaction and ask for enough steadiness to make the call."

Step 3

Tap three or four comfortable points:

"This tension."

"The fear of what they may say."

"I can ask one question at a time."

"I can remain respectful and clear."

Step 4

Stop and decide:

"Will another round help, or is it time to make the call?"

Brief practice should support action rather than become repeated postponement.

14.6 Daily Practice Without a Crisis

SEFT does not need to be reserved for intense distress. A short daily practice may help a person notice emotional accumulation before it becomes overwhelming.

A daily review may ask:

1. What affected me today?
2. Which emotion remains active?
3. Where do I feel it in my body?
4. Is practical action required?
5. What is outside my control?
6. What spiritual or personal value do I want to bring to the situation?

A daily set-up might be:

"Even though I am carrying tension from several conversations today, I acknowledge that my body needs time to settle. I can review what requires action and release what does not need to be solved tonight."

Daily use should not become compulsory. Missing a practice session is not a moral or spiritual failure.

14.7 Morning Practice

Morning practice may focus on preparation rather than symptom removal.

Possible statement:

"Even though I feel uncertain about today's responsibilities, I can approach them one at a time. O Allah, guide me towards patience, clarity, and responsible action."

A brief sequence may include:

"Today's responsibilities."

"This uncertainty."

"One task at a time."

"I can ask for help."

"I will act within my ability."

Morning practice should not become an attempt to predict or control every event of the day.

14.8 Evening Practice

Evening practice may support emotional closure.

Possible questions include:

- What am I still carrying from today?
- Is there anything that must be addressed tomorrow?
- Am I replaying a conversation that cannot be resolved tonight?
- Does my body need rest rather than more analysis?

A possible statement is:

"Even though part of my mind is still inside today's argument, the conversation is not continuing at this moment. I can write down what needs attention and allow myself to rest."

The person should not use SEFT to force sleep. Persistent sleep disturbance may require appropriate assessment and treatment.

14.9 Practice Before a Known Stressor

SEFT may be used before:

- an interview;
- presentation;
- medical procedure;
- examination;
- difficult conversation;
- journey;
- legal appointment;
- performance;
- important meeting.

The focus should be the most specific anticipated difficulty.

Instead of:

"Everything about tomorrow."

Use:

“The moment I begin speaking.”

A preparatory round may include:

“The fear of forgetting my words.”

“The image of the audience.”

“The pressure in my throat.”

“I can pause.”

“I can speak one sentence at a time.”

“I will use my preparation and surrender the outcome.”

Practice should be followed by real preparation.

14.10 Practice After a Stressor

After an event, SEFT may help reduce emotional residue.

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The person can identify:

- the strongest moment;
- the emotion;
- bodily activation;
- what action remains necessary.

Example:

“Even though I am still replaying the way my colleague spoke to me, I acknowledge the anger and humiliation. I will allow the first emotional wave to settle before deciding whether a response is necessary.”

The person should avoid using tapping only to silence themselves when a legitimate boundary has been crossed.

14.11 Journaling and Practice Records

A brief record improves clarity and helps determine whether SEFT is producing meaningful change.

Useful entries include:

- date;
- selected target;
- initial emotion;
- initial distress;
- set-up statement;
- reminder phrase;
- final distress;
- what changed;
- what remained;
- practical action;
- support required.

A journal should not become a place for endless symptom monitoring. Excessive checking may increase anxiety in some people.

The record should be brief enough to support observation without taking over the practice.

Example Entry

Date: 4 August
Target: Fear before departmental presentation
Emotion: Anxiety
Body: Tight throat
Initial rating: 7
Final rating: 4
New aspect: Fear of one senior colleague's question
Action: Prepare a concise answer and supporting reference
Follow-up: Reassess tomorrow

The record does not prove clinical effectiveness. It helps the individual recognize patterns.

14.12 What Progress May Look Like

Progress is not limited to a lower distress score.

Possible signs include:

- identifying emotions more accurately;
- recovering more quickly after a trigger;
- reduced impulsive behavior;
- greater ability to set boundaries;
- improved follow-through;
- less avoidance;
- clearer communication;
- increased willingness to seek help;
- greater spiritual honesty;

- reduced self-condemnation;
- better separation of present events from past experiences.

A person may still experience anxiety but attend the meeting. Another may continue to feel grief but resume daily responsibilities. These changes may be more meaningful than complete emotional absence.

14.13 When Repeated Practice Is Not Helping

SEFT should be reviewed when:

- the same concern is tapped repeatedly without change;
- distress rises after each practice;
- self-criticism increases;
- the person becomes dependent on tapping before every action;
- medical or psychological care is being delayed;
- the person uses tapping to avoid decisions;
- traumatic memories repeatedly emerge;
- the practice becomes compulsive;
- functioning continues to deteriorate.

The appropriate response may be:

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- changing the target;
- reducing practice frequency;
- seeking supervision;
- obtaining medical assessment;
- beginning psychotherapy;
- using another evidence-based intervention;
- stopping SEFT.

A method should not be continued indefinitely merely because the person has invested time or money in it.

14.14 Tapping as Reassurance-Seeking

A person with anxiety may begin tapping repeatedly to obtain certainty:

“I must tap until I know nothing bad will happen.”

This can strengthen dependence on the ritual.

A more balanced statement is:

“I can use one brief round to regulate myself, but tapping cannot guarantee the future. I will make the decision using available evidence.”

The goal is emotional flexibility, not ritualized certainty.

14.15 Structure of a Guided SEFT Session

A guided session may last between thirty and sixty minutes depending on the setting, concern, and practitioner's role.

A professional structure includes the following stages.

1. Opening and Review

Discuss:

- present condition;
- changes since the previous session;
- medication or treatment changes;
- new risks;
- current functioning;
- the person's goal.

2. Consent and Boundaries

Confirm:

- willingness to use SEFT;
- spiritual language preference;
- no-touch or touch arrangements;
- right to stop;
- session limits.

3. Target Selection

Choose one specific and manageable issue.

4. Baseline Assessment

Record:

- emotion;
- body sensation;
- thought;
- distress rating;
- action urge;
- functional impact.

5. Set-Up

Develop language collaboratively.

6. Tune-In and Tapping

Use one short round and observe carefully.

7. Reassessment

Ask what changed rather than assuming improvement.

8. Further Work

Complete another round only when appropriate.

9. Integration

Identify:

- new perspective;
- boundary;
- communication need;
- behavioral action;
- medical or professional follow-up.

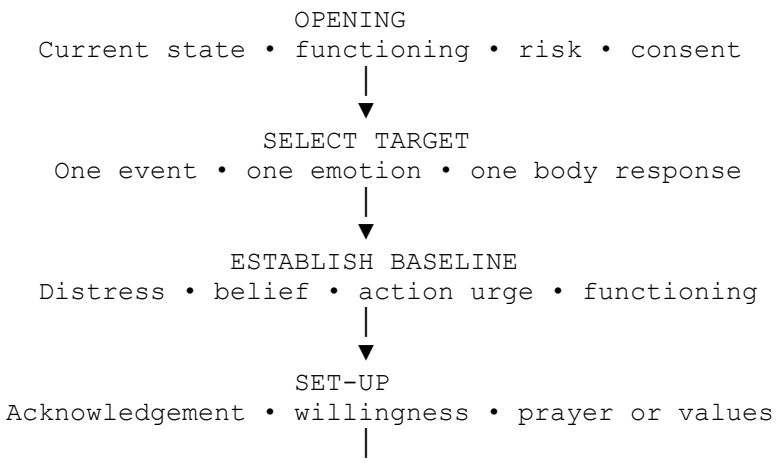
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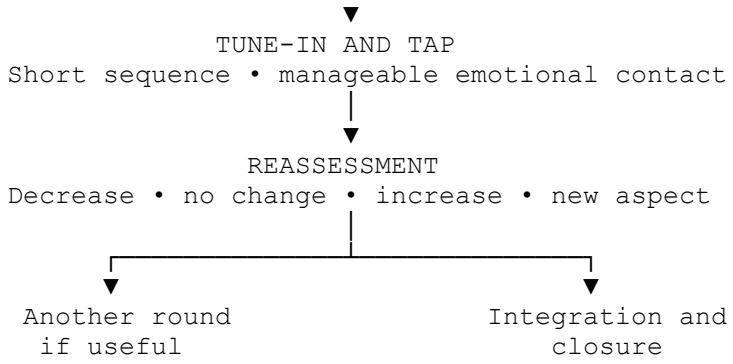
10. Closure

Return attention to the present, summaries, and agree on the next step.

Figure 15

Structure of a Guided Session





14.16 The Practitioner's Language

The practitioner should use tentative rather than authoritative language.

Prefer:

"What do you notice?"

"Does this wording fit?"

"Would you like to continue?"

"Is the emotion anger, hurt, or something else?"

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Avoid:

"Your subconscious is resisting."

"This proves the blockage is releasing."

"I know the real cause."

"You must continue."

The person's report should remain the primary source of information about the internal experience.

14.17 Following the Person, Not the Script

A prepared script provides structure but should not override the participant's response.

Suppose the planned target is anxiety, but the person says:

"The anxiety has reduced, and now I feel angry."

The practitioner should not continue repeating:

"This anxiety."

The next round may focus on:

"This anger that nobody listened."

The procedure follows the active experience.

14.18 Silence During Guided Practice

Silence may be useful when the person needs time to notice internal change.

The practitioner should not fill every pause with interpretation.

A brief question is enough:

"What is present now?"

The person may need several moments before answering.

Silence should not become abandonment. The practitioner remains attentive and available.

14.19 Guided Practice with Spiritual Language

The practitioner should not write the person's prayer without collaboration.

Ask:

"What would you like to ask for?"

The answer may be:

- patience;
- courage;
- justice;
- forgiveness;
- understanding;
- safety;
- acceptance;
- clarity;
- strength to act.

A guided statement might be:

"Even though I feel frightened about the conversation, I acknowledge the fear. O Allah, help me speak truthfully, listen carefully, and maintain my dignity."

The practitioner should not require the person to surrender a specific outcome when they are not ready.

Possible language is:

“I am willing to accept that I cannot control the other person’s response.”

This is different from:

“I accept whatever they do.”

14.20 Guided Practice without Religious Language

A participant may prefer values-based language:

“Even though I feel anxious about the conversation, I want to respond with dignity, honesty, and self-respect.”

The practitioner should not treat secular language as a reduced or inferior form of practice.

Spiritual sensitivity includes respect for:

- strong religious belief;
- uncertain belief;
- changing belief;
- nonreligious values;
- spiritual conflict.

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14.21 Practice with a Translator or Interpreter

When language support is required:

- use a qualified interpreter when possible;
- explain confidentiality;
- speak directly to the participant;
- avoid long statements;
- check the meaning of spiritual terms;
- allow additional time;
- confirm that the interpreter is not adding advice.

Family members may be unsuitable interpreters for sensitive trauma, relationship, medical, or spiritual concerns.

The set-up statement should remain understandable in the participant’s preferred language.

14.22 Group SEFT Practice

Group practice may be used in:

- educational workshops;
- healthcare settings;
- universities;
- community programs;
- staff-wellness sessions;
- rehabilitation groups;
- spiritual-care programs.

The facilitator should clearly state that a group exercise is not individual psychotherapy.

Participants should:

- choose a mild concern;
- keep private details private;
- remain free to observe;
- avoid tapping intimate or uncomfortable points;
- stop when needed;
- know where support is available.

The facilitator should not invite the group to work on:

- severe childhood trauma;
- sexual abuse;
- domestic violence;
- suicidal experiences;
- psychosis;
- recent bereavement with severe instability;
- private religious conflict.

14.23 Group Session Structure

A safe introductory group session may include:

1. explanation of SEFT;
2. limitations and consent;
3. neutral tapping-point practice;
4. selection of a low-intensity concern;
5. baseline rating;
6. one short guided round;
7. private reassessment;
8. grounding;
9. discussion of general observations;

10. referral information.

Participants should not be asked to announce their distress rating publicly.

14.24 Group Script for General Tension

"Even though I am carrying some tension today, I acknowledge that my mind and body have been managing several demands. I am willing to become slightly more settled and identify one helpful next step."

Reminder phrases:

"This general tension."

"The pressure of several demands."

"I do not need to solve everything during this exercise."

"I can become slightly steadier."

"One responsible step."

This script avoids assuming that every participant shares the same religion or emotional history.

14.25 Teaching SEFT to Families

Family members may learn simple tapping for ordinary stress, but they should not become untrained therapists to one another.

Helpful family practices include:

- asking permission;
- allowing privacy;
- demonstrating rather than touching;
- avoiding interpretation;
- stopping when requested;
- encouraging professional care.

A spouse should not say:

"You need to tap because you are overreacting."

A more respectful statement is:

"Would a brief grounding or tapping exercise be helpful, or would you prefer space?"

Children should not be pressured to tap for the convenience of adults.

14.26 Partner-Assisted Practice

A supportive partner may:

- read the tapping sequence;
- remind the person of the agreed statement;
- help record ratings;
- remain present;
- encourage stopping when needed.

The partner should not:

- demand disclosure;
- touch without consent;
- decide what the person "really feels";
- use spiritual authority;
- argue with the emotional response;
- treat SEFT as a substitute for relationship accountability.

Partner assistance is inappropriate where coercion, intimidation, or abuse is present.

14.27 Professional Training Practice

Students learning SEFT should practice first with:

- neutral targets;
- mild performance anxiety;
- ordinary frustration;
- tapping-point location;
- statement construction;
- closure procedures.

Training should include:

- ethics;
- consent;
- trauma awareness;
- medical boundaries;
- spiritual diversity;
- risk and referral;
- documentation;
- research literacy.

A learner should not be encouraged to demonstrate competence by processing severe trauma in front of a training group.

14.28 Peer Practice

Peer practice can support skill development, but the roles must remain clear.

Before beginning, agree:

- who is practitioner and participant;
- the time limit;
- the level of issue;
- confidentiality;
- the stop signal;
- whether feedback will follow;
- what will happen if serious material emerges.

Peers should not attempt to treat concerns beyond their competence.

14.29 Evaluating Practitioner Competence

Competence should be assessed through more than attendance at a workshop.

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Relevant abilities include:

- explaining SEFT accurately;
- obtaining consent;
- selecting safe targets;
- developing credible statements;
- recognizing distress escalation;
- responding to dissociation;
- maintaining boundaries;
- integrating spirituality respectfully;
- referring appropriately;
- documenting clearly;
- receiving supervision.

Technical fluency without ethical judgment is insufficient.

14.30 Monitoring Progress Over Time

A progress review may occur every three to five sessions or after a defined self-practice period.

Review:

Symptoms

- Has distress reduced?
- Are triggers less frequent or intense?
- Has another problem become more prominent?

Functioning

- Is the person sleeping, working, studying, communicating, or caring for themselves more effectively?

Behavior

- Is avoidance decreasing?
- Are impulsive reactions reduced?
- Are necessary tasks being completed?

Relationships

- Are boundaries clearer?
- Is communication improving?
- Is the person becoming isolated?

Spiritual Well-Being

- Is prayer or spiritual reflection becoming more supportive?
- Has spiritual guilt increased?
- Does the person feel pressured to believe something?

Treatment Integration

- Is medical or psychological care continuing?
- Are medication decisions being made appropriately?
- Is referral required?

Progress should not be defined only by whether the person enjoys SEFT.

14.31 Goal Attainment Review

The person can rate progress towards a specific goal.

Example goal:

“Deliver the presentation despite anxiety.”

Possible outcomes:

- **Much less than expected:** Did not attend because of anxiety.
- **Less than expected:** Attended but could not present.
- **Expected outcome:** Presented with manageable anxiety.
- **More than expected:** Presented and answered questions.
- **Much more than expected:** Presented, answered questions, and volunteered for another session.

This approach links emotional work with observable functioning.

14.32 Ending a Guided Session

The final minutes should include:

1. orientation to the present;
2. final distress rating;
3. identification of what changed;
4. recognition of what remains;
5. practical action;
6. support plan;
7. decision about future practice.

A closing statement may be:

"I acknowledge the work completed today. I do not need to resolve the whole issue now. I can remain attentive to what I need and seek further support when necessary."

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A spiritual version may be:

"Alhamdulillah for the ability to face part of this experience. O Allah, guide me towards the next wise action and help me respect my limits."

14.33 When to End a Course of SEFT

A course may end when:

- agreed goals have been reached;
- the person can practice independently;
- another treatment is more appropriate;
- no meaningful progress is occurring;
- the practitioner's competence is insufficient;
- the person chooses to stop;
- circumstances change;
- boundaries or trust have been disrupted.

Ending should be discussed rather than occurring through unexplained withdrawal.

The practitioner should review:

- skills learned;
- remaining concerns;
- relapse or recurrence plan;
- support resources;
- referral needs;
- future contact boundaries.

14.34 Ending Is Not Failure

SEFT may be discontinued because:

- the method does not fit;
- another intervention is preferred;
- distress is increasing;
- practical barriers exist;
- the person no longer wants spiritual content;
- the therapeutic relationship is not helpful.

The person should not be told:

"You are leaving because you are afraid of healing."

Respecting the decision to stop is part of informed consent.

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14.35 Recurrence and Maintenance

Emotional distress may return when:

- another reminder appears;
- sleep decreases;
- stress increases;
- a new loss occurs;
- the person enters a similar situation;
- anniversaries approach;
- physical illness worsens.

Recurrence does not necessarily mean that previous work was ineffective. Human emotional responses are influenced by changing circumstances.

A maintenance plan may include:

- brief self-practice;
- journaling;
- social support;

- medical follow-up;
- psychotherapy;
- rest and pacing;
- prayer or spiritual care;
- review of boundaries;
- renewed guided sessions where appropriate.

The person should not become dependent on daily tapping if ordinary functioning is possible without it.

14.36 Relapse-Prevention Questions

Ask:

1. What are my early warning signs?
2. Which triggers are predictable?
3. Which SEFT statement is useful?
4. When should I stop self-practice?
5. Who can provide support?
6. Which professional should I contact?
7. What practical action usually helps?
8. Which spiritual belief supports me without creating blame?

A written plan is more useful than relying on memory during high distress.

14.37 A Personal Practice Plan

Frequency

Choose:

- as needed;
- once daily for a limited period;
- before known stressors;
- after difficult events;
- according to a professional plan.

Duration

Set a limit:

“Ten minutes, followed by reassessment.”

Target

Use one specific issue.

Stop Criteria

Stop if:

- distress rises sharply;
- orientation decreases;
- physical discomfort develops;
- traumatic material becomes overwhelming;
- the practice becomes repetitive without benefit.

Support

Record:

- practitioner;
- physician;
- family member;
- emergency resource;
- spiritual adviser.

14.38 Responsible Self-Reliance

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SEFT may strengthen self-efficacy when the person learns:

"I can influence how I respond."

This should not become:

"I must manage everything alone."

Responsible self-reliance includes knowing when to seek assistance.

A mature practice balances:

- personal effort;
- professional care;
- social support;
- spiritual trust;
- acceptance of limitation.

14.39 Chapter Summary

SEFT may be practiced independently for mild or moderate concerns when the person remains oriented, physically safe, and able to stop. Severe trauma, suicidality, psychosis, dissociation, violence, and medical emergencies require appropriate professional or urgent care.

A brief self-practice session includes orientation, selection of one target, baseline assessment, set-up, tapping, reassessment, and practical action. Daily practice may support awareness, but it should not become compulsory, compulsive, or a substitute for treatment.

Guided practice requires consent, collaborative language, careful target selection, risk awareness, and structured closure. The practitioner follows the participant's current experience rather than forcing a prepared script.

Group sessions should use low-intensity concerns, preserve privacy, and avoid severe trauma. Family members and peers may provide support but should not assume unqualified therapeutic authority.

Progress should be evaluated through functioning, behavior, communication, boundaries, and access to support not only through lower distress ratings.

A course of SEFT may end because goals have been reached, another treatment is needed, the method is not helpful, or the person chooses to stop. Ending should be respectful and planned.

The central principle is:

SEFT should increase a person's capacity to observe, choose, act, seek support, and live according to meaningful values. It should not create dependency on the technique or practitioner.

Self-Practice Record

Date and time:

Current location:

The specific concern is:

The main emotion is:

The bodily sensation is:

Initial distress:
_____ /10

The main thought is:

Set-Up Statement

"Even though _____
when I think about _____
I acknowledge _____
and ask for _____

Reminder Phrase

After the Round

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Final distress:
_____ /10

What changed:

What remains:

Did another emotion or memory emerge?

My next responsible action is:

Do I need guided or professional support?
☐ No

☐ Yes
☐ Unsure

Guided Session Review Form

Session date:

Presenting concern:

Consent confirmed:
☐ Yes

Spiritual preference:
☐ Explicit prayer
☐ Quiet spiritual intention
☐ Secular language
☐ No spiritual language

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Selected target:

Initial distress:
_____ /10

Final distress:
_____ /10

Change in functioning or action urge:

New aspect identified:

Grounding or closure used:

Risk or referral concern & Agreed next step

PRACTICAL WORKSHEETS AND APPENDICES

The following materials are designed for educational, self-practice, professional, training, and research settings. They should be adapted to the practitioner's professional role, local laws, institutional requirements, and the participant's language, culture, abilities, and beliefs.

The forms do not qualify an unlicensed or inadequately trained person to diagnose, treat, or manage a psychological or medical condition.

Appendix A

One-Page SEFT Practice Guide

Before Beginning

Confirm that:

☐ I am physically safe.
☐ There is no immediate medical or psychiatric emergency.
☐ I can remain aware of my surroundings.
☐ I am working with a mild or manageable concern.
☐ I can stop whenever I choose.
☐ I am not using SEFT instead of necessary treatment.

1. Select One Specific Target

Avoid:

"My whole life."

"All my anxiety."

Choose:

"The tightness in my throat when I think about tomorrow's presentation."

2. Identify the Experience

Situation:

Emotion:

Bodily sensation:

Main thought:

Initial intensity:
_____ /10

3. Form the Set-Up Statement

Tap gently on the side of the hand:

"Even though I feel _____
when I think about _____
I acknowledge _____
and ask for _____

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Repeat the statement up to three times.

4. Tune In

Notice only one manageable aspect:

- the emotion;
- bodily sensation;
- image;
- thought;
- memory;
- anticipated situation.

5. Tap Through the Short Sequence

1. Top of head
2. Beginning of eyebrow
3. Side of eye
4. Under eye
5. Under nose

6. Chin
7. Collarbone
8. Under arm
9. Return to top of head

Use a brief phrase at each location:

“This remaining fear.”

“This pressure in my chest.”

“I can remain present.”

6. Pause and Reassess

Intensity after the round:
_____ /10

What changed?

What remains?

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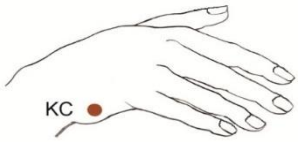
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7. Identify Responsible Action

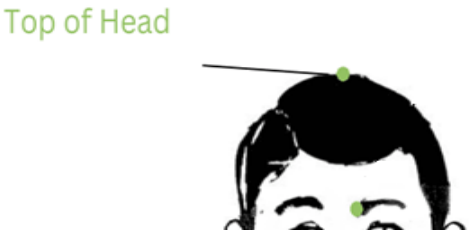
“The next action within my control is…”

Stop Immediately When

- distress rises sharply;
- the surroundings begin to feel unreal;
- severe panic or confusion develops;
- a medical symptom worsens;
- a traumatic memory becomes overwhelming;
- an urge to harm yourself or another person emerges.


KC


Karate


Top of Head


Beginning of
Eyebrow


Side of Eye

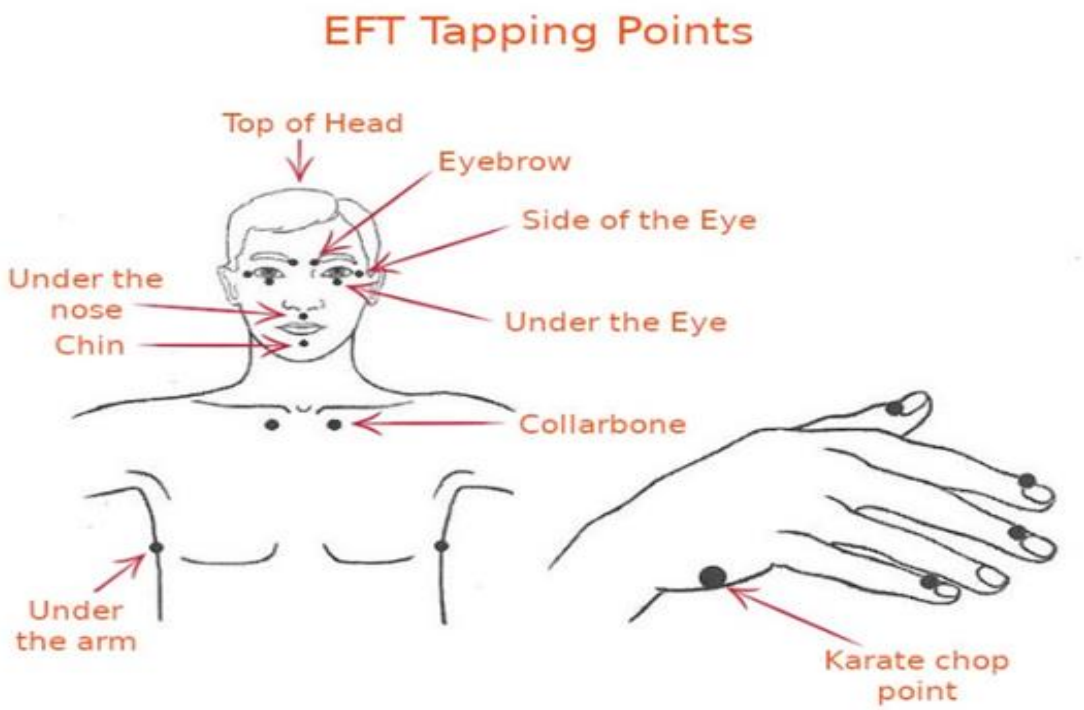

Under Eye


Below Nose


Middl
10cm below
armpit
Under Arm



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Appendix B

Self-Practice Safety Screen

Complete this screen before independent SEFT practice.

Current Safety

1. Am I in immediate physical danger?

☐ No
☐ Yes
☐ Unsure

2. Am I experiencing a medical emergency?

☐ No
☐ Yes
☐ Unsure

3. Am I thinking about harming myself?

☐ No
☐ Yes
☐ Unsure

4. Am I thinking about harming another person?

☐ No
☐ Yes
☐ Unsure

5. Am I intoxicated or experiencing substance withdrawal?

☐ No
☐ Yes
☐ Unsure

6. Am I hearing or seeing things that other people do not appear to perceive?

☐ No
☐ Yes
☐ Unsure

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7. Do I feel severely confused, unreal, detached from my body, or unable to identify where I am?

☐ No
☐ Yes
☐ Unsure

A **yes** or **unsure** response to any of these questions indicates that self-directed emotional processing may be inappropriate. Obtain suitable medical, psychological, safeguarding, crisis, or emergency support.

Emotional Capacity

8. Can I stop thinking about the issue when I choose?

☐ Yes
☐ No
☐ Unsure

9. Can I feel my feet, hands, or the support beneath me?

☐ Yes
☐ No
☐ Unsure

10. Can I identify today's date and my current location?

☐ Yes
☐ No
☐ Unsure

11. Is the issue mild or moderately distressing rather than overwhelming?

☐ Yes
☐ No
☐ Unsure

12. Is support available if I become distressed?

☐ Yes
☐ No

Treatment Check

13. Have concerning physical symptoms received appropriate medical assessment?

☐ Yes
☐ No
☐ Not applicable

14. Am I continuing prescribed treatment unless a qualified clinician changes it?

☐ Yes
☐ No
☐ Not applicable

15. Am I using SEFT as support rather than as a substitute for necessary care?

☐ Yes
☐ No

Decision

☐ Self-practice appears appropriate for a limited concern.
☐ I will use grounding only.
☐ I will seek guided professional support.
☐ I require urgent assistance.

Personal Stop Card

My stopping signal is:

The first sign that I am becoming overwhelmed is:

My grounding method is:

The person or service I will contact is:

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Appendix C

Professional SEFT Intake Form

Participant Information

Name:

Preferred name:

Age:

Pronouns, where relevant:

Contact information:

Emergency contact:

Current location for online work:

Presenting Concern

What brings you to this service?

How long has the concern been present?

What situations make it stronger?

What helps reduce it?

Current Functioning

Rate the effect of the concern from 0 to 10:

Area	Rating
Sleep	
Work or study	
Family life	
Social relationships	
Physical self-care	
Concentration	
Spiritual well-being	
Overall daily functioning	

Medical Information

Current medical conditions:

Current medication:

Recent medication changes:

Current treating professionals:

Unexplained or worsening physical symptoms:

Psychological History

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Previous counselling or psychotherapy:

Current psychological treatment:

Previous psychiatric diagnosis, where relevant:

Previous hospitalization:

History of self-harm or suicidal thinking:

History of psychosis, mania, or severe dissociation:

Trauma and Safety

The participant does not need to provide detailed traumatic information during initial screening.

Is there a history of a highly distressing or traumatic experience?

☐ No
☐ Yes
☐ Prefer not to answer

Is danger ongoing?

☐ No
☐ Yes
☐ Unsure

Is domestic abuse, coercion, stalking, or safeguarding concerns present?

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☐ No
☐ Yes
☐ Unsure

Substance Use

Alcohol or substance use that may affect treatment:

Spiritual and Cultural Preferences

Would you like spiritual or religious language included?

☐ Yes
☐ No
☐ Decided session by session
☐ Unsure

Preferred spiritual wording or tradition:

Words, practices, or interpretations that should not be used:

Initial Professional Decision

☐ Suitable for low-intensity SEFT support
☐ Requires further assessment
☐ Requires medical clearance
☐ Requires trauma-specialist assessment
☐ Requires safeguarding action
☐ Requires emergency or crisis assistance
☐ Outside practitioner's competence

Rationale:

Appendix D

Informed-Consent Form

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Nature of the Practice

Spiritual Emotional Freedom Technique combines focused attention to an emotional or bodily concern with gentle self-tapping on selected areas of the hand, head, face, and upper body. It may include acceptance-based, values-based, or spiritual language according to the participant's preference.

Possible Benefits

Some participants report:

- reduced subjective distress;
- greater emotional awareness;
- reduced bodily tension;
- improved ability to think before acting;
- increased sense of personal control;
- spiritual comfort.

These outcomes cannot be guaranteed.

Possible Discomfort

The practice may temporarily activate:

- uncomfortable emotions;
- memories;
- bodily sensations;
- anxiety;
- sadness;
- anger;
- spiritual conflict.

The participant may pause or stop at any time.

Limitations

SEFT is not a substitute for:

- medical diagnosis;
- emergency care;
- prescribed treatment;
- psychiatric assessment;
- evidence-based trauma treatment;
- safeguarding;
- legal protection;
- rehabilitation.

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Practitioner Role

Practitioner's professional qualification:

SEFT training:

Professional role in this service:

Spiritual Language

☐ I consent to explicit spiritual or religious language.
☐ I prefer neutral or secular language.
☐ I will decide during each session.
☐ I do not consent to spiritual language.

Physical Contact

The normal procedure is self-tapping.

☐ I understand that I will tap on myself.
☐ I do not consent to practitioner touch.
☐ Any proposed touch must be explained and separately agreed.

Confidentiality

Information will be kept confidential within professional and legal limits. Possible exceptions may include:

- serious and imminent risk;
- abuse or safeguarding concerns;
- legal requirements;
- consultation or supervision conducted with appropriate privacy protection.

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Records

Type of records kept:

Storage method:

Retention period:

Online Sessions

For online work, I understand that:

- privacy cannot be guaranteed when others are nearby;
- the practitioner may need my current location;
- an alternative contact method is required;
- emergency procedures will be discussed;
- recording is prohibited unless separately agreed.

Voluntary Participation

I understand that:

☐ Participation is voluntary.
☐ I may ask questions.
☐ I may decline any statement or procedure.
☐ I may stop a session.
☐ I may seek another opinion or treatment.
☐ No outcome has been guaranteed.

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Participant's name:

Signature:

Date:

Practitioner's signature:

Appendix E

Professional Session Record

Administrative Information

Participant:

Date:

Session number:

Duration:

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Format:
☐ In person
☐ Online
☐ Group
☐ Another format

Opening Review

Current emotional condition:

Current functioning:

Changes in medication or treatment:

New risk or safeguarding concern:

Consent reconfirmed:
☐ Yes
☐ No

Selected Target

Specific event, thought, image, sensation, or trigger:

Primary emotion:

Secondary emotion:

Bodily sensation:

Main belief or interpretation:

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Initial distress:
_____ /10

Action urge, where relevant:
_____ /10

Functional interference:
_____ /10

Spiritual Preference

☐ Explicit prayer
☐ Values-based wording
☐ Secular wording
☐ No spiritual language

Chosen wording:

Set-Up Statement

Tapping Procedure

☐ Short sequence
☐ Extended sequence
☐ Adapted sequence
☐ No physical tapping

Points omitted or modified:

Number of rounds:

Participant Response

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Final distress:
_____ /10

Final action urge:
_____ /10

Change in bodily sensation:

New aspect or memory:

Participant's description of change:

Safety and Stabilization

Signs of overwhelm or dissociation:

Grounding used:

Session stopped early:
☐ No
☐ Yes

Reason:

Integration

New perspective:

Practical action:

Referral or consultation:

Plan for next session:

Appendix F

Trauma-Informed Stabilization Form

This form is not a trauma-treatment protocol. It supports assessment of whether trauma-related tapping should proceed, remain limited to grounding, or stop.

Present Safety

Is the traumatic danger fully in the past?

☐ Yes
☐ No
☐ Uncertain

Is there current contact with the person or situation involved?

☐ No
☐ Yes
☐ Uncertain

Is immediate protective action needed?

☐ No
☐ Yes
☐ Uncertain

Present Orientation

Ask the participant to state:

Current location:

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Current date:

Current age:

Difference between the present setting and the event setting:

Regulation Capacity

Can the participant move attention away from the memory?

☐ Yes
☐ No
☐ Inconsistently

Can the participant feel the chair, floor, or body?

☐ Yes
☐ No
☐ Inconsistently

Can the participant communicate a stop request?

☐ Yes
☐ No

Can the participant tolerate a small reminder without losing orientation?

☐ Yes
☐ No
☐ Unclear

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Dissociation Indicators

☐ Staring or loss of responsiveness
☐ Surroundings feel unreal
☐ Feeling outside the body
☐ Numbness
☐ Memory gaps
☐ Sudden loss of speech
☐ Confusion about time or location
☐ Abrupt change in posture or awareness
☐ None observed or reported

Current Risk

☐ Suicidal thinking
☐ Self-harm
☐ Violence towards others
☐ Psychosis
☐ Mania
☐ Severe substance misuse

☐ Domestic violence
☐ Child or vulnerable-person safeguarding concern
☐ Medical emergency
☐ None identified

Decision

☐ Continue with present-moment grounding only.
☐ Use a low-intensity present trigger.
☐ Use a private title without detailed disclosure.
☐ Postpone emotional processing.
☐ Refer for trauma-specialist assessment.
☐ Initiate safeguarding or emergency procedure.

Grounding Plan

Visual orientation:

Physical grounding:

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Supportive phrase:

Spiritual phrase, where chosen:

Stop signal:

Post-session support:

Appendix G

Progress-Review Form

Complete after an agreed number of sessions or a defined self-practice period.

Original Goal

Emotional Change

Indicator	Beginning	Current
Distress intensity	____	____
Trigger frequency	____	____
Recovery time	____	____
Self-criticism	____	____
Emotional avoidance	____	____

Functional Change

Area	Worse	Unchanged	Improved
Sleep	☐	☐	☐
Work or study	☐	☐	☐
Communication	☐	☐	☐
Self-care	☐	☐	☐
Relationships	☐	☐	☐
Medical adherence	☐	☐	☐
Boundary-setting	☐	☐	☐
Decision-making	☐	☐	☐

Spiritual Change

Spiritual language has felt:

☐ Supportive
☐ Neutral
☐ Pressuring
☐ Confusing
☐ Variable
☐ Not used

Spiritual guilt has:
☐ Decreased
☐ Increased
☐ Remained unchanged

Prayer or values-based reflection has supported:

Practice Use

Frequency of self-practice:

Has practice become repetitive or compulsive?

☐ No
☐ Yes
☐ Unsure

Is SEFT being used instead of necessary action or treatment?

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☐ No
☐ Yes
☐ Unsure

Overall Decision

☐ Continue the present plan.
☐ Modify the target or wording.
☐ Reduce frequency.
☐ Increase professional support.
☐ Refer to another service.
☐ End SEFT.
☐ Move to maintenance.

Rationale:

Appendix H

Course-Closure Form

Goals Reached

Skills Developed

☐ Identifying emotions
☐ Rating distress
☐ Locating bodily sensations
☐ Creating specific statements
☐ Grounding
☐ Setting boundaries
☐ Delaying impulsive action
☐ Seeking support
☐ Spiritual reflection without self-blame
☐ Independent self-practice

Remaining Concerns

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Reason for Ending

☐ Goals reached
☐ Participant's choice
☐ Another treatment is more appropriate
☐ No meaningful benefit
☐ Practitioner's competence exceeded
☐ Practical barriers
☐ Boundary or relationship issue
☐ Another reason

Maintenance Plan

Warning Signs Requiring Further Help

Appendix I

Group Workshop Plan

Recommended Workshop Title

Introduction to Spiritual Emotional Freedom Technique:
Emotional Regulation, Spiritual Choice, and Safe Self-Practice

Appropriate Audience

- university students;
- healthcare staff;
- educators;
- community groups;
- counsellors in training;
- rehabilitation participants;
- adults seeking basic stress-management education.

Learning Outcomes

By the end of the workshop, participants should be able to:

1. distinguish EFT, SEFT, and Emotionally Focused Therapy;
2. describe the set-up, tune-in, and tapping stages;
3. identify the short tapping sequence;
4. develop a specific and credible statement;
5. recognize safety and referral limits;
6. explain that spiritual language requires consent;
7. use a brief practice for ordinary stress.

Suggested Two-Hour Schedule

Time	Topic
0–15 minutes	Introduction, definitions, limits
15–30 minutes	Emotion–thought–body–spirit framework
30–45 minutes	Safety, consent, and referral
45–60 minutes	Tapping-point demonstration
60–70 minutes	Break
70–90 minutes	Statement development
90–105 minutes	Low-intensity guided practice
105–115 minutes	Private reassessment and questions
115–120 minutes	Closure and support resources

Group Safety Statement

"This workshop is educational and is not individual psychotherapy. Please select only a mild concern. You do not need to disclose personal details or your rating. You may observe without participating, skip any point, change the wording, or stop at any time."

Group Practice Target

Suitable:

"General tension associated with today."

Not suitable:

"The worst event of your life."

Facilitator Checklist

☐ Qualifications described accurately
☐ Recording policy explained
☐ Spiritual neutrality stated
☐ No public trauma processing
☐ No participant touch
☐ Private disclosure not required
☐ Referral information available
☐ Grounding completed before closing

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Participant Group Agreement

I understand that:

☐ This is an educational exercise.
☐ I may keep my issue private.
☐ I will select a low-intensity concern.
☐ I will not record other participants.
☐ I will not repeat another person's disclosure.
☐ I may stop or leave the exercise.
☐ This workshop does not replace treatment.

Appendix J

Research Protocol Checklist for SEFT Studies

SEFT research requires precise reporting because protocols vary widely.

Research Question

Primary question:

Primary hypothesis:

Primary outcome:

Follow-up period:

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Population

Specify:

- age;
- sex or gender characteristics;
- diagnosis or screening criterion;
- cultural setting;
- religious or spiritual background;
- inclusion criteria;
- exclusion criteria;
- concurrent treatment.

Intervention Description

Report:

☐ Set-up statement
☐ Tune-in procedure
☐ Tapping points
☐ Point sequence

☐ Number of taps
☐ Session duration
☐ Number of sessions
☐ Practitioner qualification
☐ Individual or group delivery
☐ Online or in-person delivery
☐ Home practice
☐ Prayer wording
☐ Surrender or acceptance wording
☐ Treatment-fidelity procedure

Comparison Condition

☐ No treatment
☐ Wait-list
☐ Treatment as usual
☐ Attention control
☐ Relaxation
☐ Standard EFT
☐ Prayer alone
☐ Sham tapping
☐ Established psychological intervention
☐ Another comparison

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Randomization

Sequence generation:

Allocation concealment:

Blinded assessors:

Sample Size

Power analysis completed:
☐ Yes
☐ No

Planned sample:

Expected attrition:

Outcomes

Include, where appropriate:

- validated self-report measures;
- diagnostic interviews;
- functional outcomes;
- behavioral outcomes;
- adverse events;
- participant acceptability;
- spiritual well-being;
- negative religious coping;
- treatment adherence;
- long-term follow-up.

Registration and Reporting

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Trial registration:

Protocol publication:

Analysis plan:

Data-sharing statement:

Conflict-of-interest declaration:

CONSORT 2025 provides a 30-item reporting checklist and participant-flow diagram for randomized trials; SEFT trials should use the current standard rather than describing randomization without full methodological reporting.

Essential Component Study

A rigorous trial examining the distinct contribution of spirituality could compare:

1. standard EFT;
2. prayer or spiritual reflection;
3. combined SEFT;
4. a credible active comparator.

Equal treatment time, expectancy, practitioner contact, and outcome assessment would be necessary.

Appendix K

Spiritual and Values-Based Language Bank

These statements are starting points, not fixed scripts. They should be changed to reflect the person's own beliefs and emotional position.

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Anxiety

Explicitly Spiritual

"O Allah, I acknowledge this fear and ask for steadiness, wisdom, and courage."

Values-Based

"I can feel anxiety and still act according to preparation, dignity, and responsibility."

Minimal

"This fear is present, and I remain here."

Anger

Explicitly Spiritual

"O Allah, help me seek justice without becoming unjust."

Values-Based

"I can protect my boundary without acting destructively."

Minimal

"This anger is information, not an instruction."

Grief

Explicitly Spiritual

"O Allah, help me carry this loss without denying the love."

Values-Based

"I can honor the relationship while gradually adapting to the loss."

Minimal

"This wave of grief."

Shame

Explicitly Spiritual

"Help me take responsibility, seek forgiveness, and resist hopelessness."

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Values-Based

"I can acknowledge the mistake without defining my complete identity by it."

Minimal

"This shame and the wish to hide."

Rejection

Explicitly Spiritual

"Guide me towards what I can learn and help me release what I cannot control."

Values-Based

"One decision does not contain the whole truth about my value."

Minimal

"This painful rejection."

Illness

Explicitly Spiritual

"Help me follow appropriate care and face uncertainty with patience."

Values-Based

"I can address the emotional burden while continuing treatment."

Minimal

"This fear connected with the symptom."

Forgiveness

When Not Ready

"I am not ready to forgive, and I will not pressure myself to pretend."

Reducing Personal Burden

"I am willing to reduce the effect this anger has on my daily life."

Maintaining Safety

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"Emotional release does not require renewed access, trust, or reconciliation."

Surrender

Balanced Surrender

"I will take the actions within my responsibility and surrender the final outcome."

Avoidance Warning

Not recommended:

"I surrender, so I no longer need to act."

Corrective Wording

"Surrender concerns the outcome, not the responsibilities that remain mine."

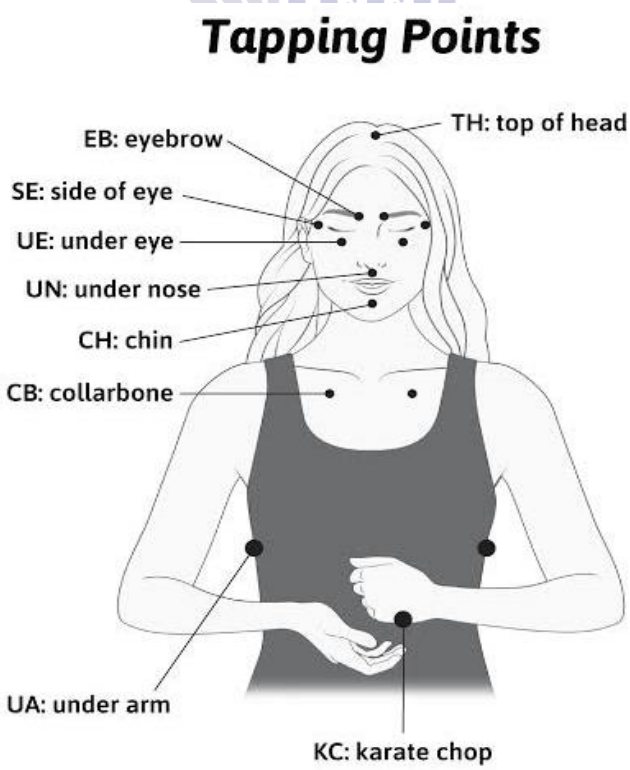
Appendix L

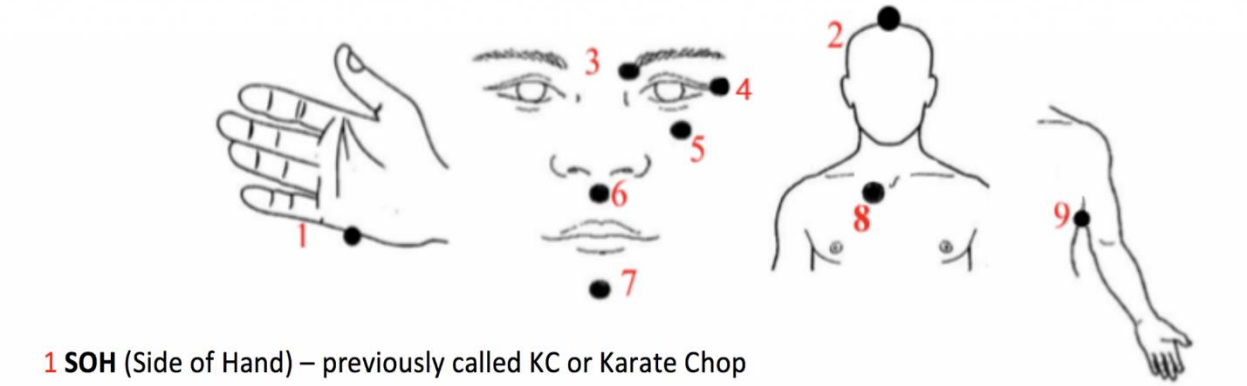
Illustration and Production Brief

Illustration 1: Tapping-Point Map

Format: Full-body or upper-body front view
Purpose: Show the short tapping sequence
Style: Professional health-education illustration
Requirements:

- side-of-hand inset;
- top-of-head point;
- eyebrow;
- side of eye;
- under eye;
- under nose;
- chin;
- collarbone;
- underarm;
- optional lower-chest point clearly labelled as optional;
- no claim that points correspond to proven emotional blockages.





1 **SOH** (Side of Hand) – previously called KC or Karate Chop
2 **TOH** (Top of Head) – crown of the head
3 **EB** (Eyebrow Point) – beginning of eyebrow, at nose edge
4 **SE** (Side of Eye) – on bone edge
5 **UE** (Under Eye) – on bone edge
6 **UN** (Under the Nose)
7 **CH** (Chin Point) – between the lower lip and the chin
8 **CB** (Collarbone or K27) – slightly underneath the bone
9 **UA** (Under the Arm) – upper side of torso, middle of bra strap

Illustration 2: Three Stages of SEFT

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A circular or horizontal process:

Set-up → Tune-in → Tapping → Reassessment → Integration

Include prayer as optional and participant-led.

Illustration 3: Emotion–Thought–Body–Spirit Model

Four overlapping circles:

- thought;
- emotion;
- body;
- spiritual meaning.

Place behavior and social context around the outside.

Illustration 4: Manageable Emotional Range

A vertical diagram showing:

- high activation;
- manageable emotional contact;
- low activation or dissociation.

Include grounding arrows returning towards the central range.

Illustration 5: Safety Decision Pathway

A flow chart:

Consent → emergency check → orientation → target suitability → practice or referral

Illustration 6: Session Structure

A professional session timeline:

Review → consent → target → baseline → tapping → reassessment → action → closure

Illustration 7: Language Ladder

Show gradual progression from:

“I am terrified”

to:

“I can take one responsible step.”

Illustration 8: Biopsychosocial-Spiritual Health Model

Show medical care, rehabilitation, psychological care, social support, and spirituality as complementary domains.

Photography Guidance

Photographs may show:

- self-tapping;
- group teaching;
- journaling;
- calm professional settings;
- culturally diverse adults.

Avoid:

- practitioner contact with intimate areas;
- dramatic crying used for promotion;
- images suggesting instant cure;
- vulnerable clients shown without robust consent;
- religious imagery that implies endorsement by one faith community.

Caption Standard

Captions should explain what the reader is observing without making a therapeutic guarantee.

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Appropriate:

“A participant demonstrates gentle self-tapping at the collarbone point.”

Inappropriate:

“Tapping this point releases anxiety energy.”

GLOSSARY

Acceptance

Willingness to recognize the presence of an internal experience without denying it or adding unnecessary self-judgment. Acceptance does not mean approval, passivity, forgiveness, or remaining in danger.

Active Control

A comparison condition in research that provides a credible intervention, attention, or therapeutic activity rather than no treatment.

Affect Labelling

Putting emotional experience into words, such as identifying a reaction as fear, anger, shame, or grief.

Adverse Event

An unwanted or harmful occurrence during or after an intervention. It may be physical, psychological, relational, spiritual, or indirect.

Allocation Concealment

A research procedure that prevents the person enrolling participants from knowing which treatment will be assigned next.

Anticipatory Anxiety

Fear or worry about an event that has not yet occurred.

Anticipatory Grief

Grief, fear, or emotional adjustment occurring before an expected death or major loss.

Autonomic Arousal

Changes in processes such as heartbeat, sweating, breathing, and muscular tension associated with activation of the autonomic nervous system.

Baseline

The initial measurement taken before an intervention, such as the first distress rating.

Blinded Assessment

Outcome evaluation conducted by a person who does not know which intervention the participant received.

Bridging Statement

A believable phrase connecting present distress with a possible next position.

Example:

"I am not calm yet, but I am open to becoming slightly steadier."

Clinical Significance

The degree to which a change is meaningful in daily life or health, rather than merely statistically detectable.

Cognitive Reappraisal

Changing the interpretation of an event in a way that modifies its emotional effect.

Competence

The knowledge, skills, judgment, supervised experience, and professional authority required to provide a service safely.

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Complex PTSD

A trauma-related disorder that includes the central features of PTSD together with persistent difficulties involving emotion regulation, negative self-concept, and relationships.

Confidentiality

The responsibility to protect private information within professional and legal limits.

Consent

Voluntary agreement based on adequate and understandable information.

Content-Free Practice

Working with a private label, emotion, bodily sensation, or distress rating without requiring detailed disclosure of the event.

Continuing Bonds

The continuing emotional, symbolic, spiritual, or values-based relationship a person may retain with someone who has died.

Control Group

The group in a study against which the intervention group is compared.

Cultural Adaptation

Modification of an intervention to fit the participant's language, values, traditions, social context, and understanding of distress.

Dissociation

A disruption or disconnection involving awareness, memory, identity, emotion, bodily experience, or perception of the surroundings.

Distress Rating

A subjective estimate of emotional intensity, commonly recorded from 0 to 10.

Dual Relationship

A situation in which the practitioner has another significant role with the participant, such as teacher, employer, examiner, religious leader, friend, or business partner.

Efficacy

The extent to which an intervention produces benefit under controlled research conditions.

Effectiveness

The extent to which an intervention produces benefit in ordinary clinical or community practice.

Effect Size

A statistical estimate of the magnitude of a difference or change.

Emotional Freedom Techniques

A tapping-based method combining focused attention, verbal statements, and stimulation of selected body points. It is commonly abbreviated as EFT.

Emotion Regulation

Processes through which people influence the intensity, duration, expression, or management of emotions.

Emotionally Focused Therapy

An attachment-based psychotherapy used particularly with couples and families. It is different from Emotional Freedom Techniques despite sharing the abbreviation EFT.

Energy Psychology

A broad family of practices that combine psychological methods with stimulation of body points or concepts derived from traditional energy models.

Exposure

Deliberate contact with a feared memory, thought, sensation, object, or situation under sufficiently safe and structured conditions.

Flashback

An intrusive trauma response in which aspects of an earlier event feel as though they are occurring in the present.

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Forgiveness

A personal process involving changes in the response to an offence. It is not automatically equivalent to reconciliation, excusing, forgetting, restoring trust, or removing consequences.

Functional Interference

The degree to which symptoms affect work, study, self-care, sleep, relationships, or other activities.

Gamut Point

A location on the back of the hand used in some extended tapping procedures.

Generalized Anxiety

Persistent and difficult-to-control worry across several areas of life, often accompanied by tension and functional impairment.

Grief

A multidimensional response to loss that may affect emotions, the body, identity, relationships, behavior, and spiritual meaning.

Grounding

Methods used to strengthen connection with present time, place, bodily contact, and immediate surroundings.

Guided Practice

SEFT facilitated by a practitioner rather than completed independently.

Informed Consent

A continuing process through which a person understands the procedure, benefits, risks, alternatives, privacy limits, and right to refuse.

Integration Statement

A phrase introduced after acknowledging distress to support a credible and responsible direction.

Interoception

Sensing and interpreting internal bodily signals.

Kinesiophobia

Fear of movement or activity because of concern about pain or physical harm.

Mechanism

A process proposed to explain how or why an intervention produces change.

Medical Red Flag

A symptom or sign indicating that urgent or further medical assessment may be necessary.

Meridian

A pathway described in traditional acupuncture systems. Meridian explanations used in tapping remain theoretically and scientifically debated.

Moral Injury

Distress associated with an event that violates deeply held moral values or involves betrayal by a trusted authority.

Negative Religious Coping

Spiritual responses involving abandonment, punishment beliefs, condemnation, or conflict with God or a religious community.

Outcome Measure

A tool used to evaluate change, such as a symptom scale, diagnostic interview, behavioral task, or physiological measure.

Pacing

Balancing activity and rest according to realistic physical capacity rather than alternating between excessive activity and collapse.

Placebo or Contextual Effect

Change influenced by expectation, ritual, meaning, attention, or the treatment environment. These effects do not mean that the person invented the improvement.

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Positive Religious Coping

Use of spiritual connection, meaning, prayer, hope, or supportive faith-community relationships to manage adversity.

Post-Traumatic Stress Disorder

A disorder that may develop after traumatic exposure and may involve intrusion, avoidance, changes in thinking and mood, and heightened arousal or reactivity.

Prayer

Communication or spiritual engagement directed towards God or a transcendent reality, according to the person's belief system.

Preregistration

Publicly recording the study hypothesis, primary outcomes, methods, and analysis plan before examining the results.

Primary Outcome

The principal result a study is designed to evaluate.

Prolonged Grief Disorder

A disorder involving persistent and impairing grief after the death of a close person, assessed in relation to time, severity, functioning, and cultural context.

Randomized Controlled Trial

A study in which participants are allocated by chance to different interventions or conditions.

Reassessment

Evaluation of what changed or remained after a tapping round or treatment period.

Reconciliation

Restoration or rebuilding of a relationship. It is separate from emotional relief or forgiveness and may be unsafe or inappropriate in some circumstances.

Referral

Directing a person to another professional or service when needs exceed the practitioner's role or competence.

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Reminder Phrase

A short phrase repeated during tapping to maintain attention on the selected target.

Researcher Allegiance

The possibility that a researcher's commitment to an intervention or theory influences study design, delivery, or interpretation.

Risk of Bias

The possibility that features of a study systematically distort its findings.

Scope of Practice

The services a practitioner is trained, competent, professionally authorized, and legally permitted to provide.

Self-Compassion

Responding to personal suffering with understanding and fairness rather than contempt, while retaining responsibility.

Self-Practice

Independent use of the method without a practitioner actively guiding the session.

Set-Up

The SEFT stage in which the person identifies the problem and develops an acknowledgement, acceptance, willingness, or prayer-based statement.

Shame

A painful self-conscious emotion involving a global negative judgment of the self.

Spiritual Consent

Specific permission to include prayer, religious language, or spiritual interpretation in a session.

Spiritual Emotional Freedom Technique

A spiritually integrated tapping practice combining set-up, tune-in, tapping, acceptance, prayer, sincerity, and surrender. It is abbreviated as SEFT.

Spiritual Struggle

Distress involving spiritual meaning, guilt, doubt, abandonment, punishment beliefs, or conflict with a religious community.

Stabilization

Work intended to increase present safety, orientation, regulation, and capacity before detailed emotional or trauma processing.

Statistical Significance

A statistical judgment concerning whether an observed result would be unlikely under a specified null hypothesis. It does not establish clinical importance.

Subjective Units of Distress Scale

A personal rating of distress, commonly ranging from 0 to 10.

Surrender

Recognition of the limits of personal control while continuing to take responsible action. It should not be confused with resignation or helplessness.

Tapping

Gentle repetitive stimulation of selected points using the fingertips.

Thought Field Therapy

An earlier tapping approach associated with Roger Callahan that influenced the development of EFT.

Titration

Approaching distressing material in small, manageable amounts.

Trauma-Focused Treatment

Structured psychological treatment that directly addresses trauma memories, meanings, avoidance, emotions, and associated patterns.

Trauma-Informed Practice

A way of delivering care that recognizes trauma, prioritizes safety and choice, and attempts to avoid re-traumatization.

Tune-In

The SEFT stage in which the person maintains gentle attention to the selected emotion, thought, image, sensation, or memory.

Values-Based Language

Wording based on chosen principles such as dignity, compassion, justice, courage, honesty, or responsibility rather than explicit religion.

Window of Tolerance

A practical metaphor for the range in which emotion is active but the person remains oriented and capable of reflection, communication, and choice.

CONCLUSION

A Practice of Awareness, Responsibility, and Spiritual Integrity

Spiritual Emotional Freedom Technique occupies an unusual position. It is neither simply a physical tapping routine nor a complete system of psychotherapy. It draws from tapping traditions, focused emotional attention, verbal acknowledgement, acceptance, prayer, self-compassion, and spiritual surrender.

Its appeal is understandable. The procedure is structured, easy to remember, physically accessible for many people, and adaptable to different concerns. It gives the person an active role rather than asking them to remain a passive recipient of help. For individuals who value spirituality, SEFT may also provide language through which emotional suffering can be acknowledged without separating psychological experience from faith and meaning.

These strengths do not remove the need for caution.

The historical theories of energy disturbance and meridian correction remain scientifically unestablished. Research concerning Clinical EFT has produced encouraging findings in areas such as anxiety, stress, depression, pain, and trauma-related symptoms, but the strength of evidence varies. Research specifically examining SEFT is smaller, less standardized, and concentrated within a limited range of cultural and research settings.

The spiritual component has not yet been isolated adequately. It is therefore not known whether prayer adds benefit beyond tapping, whether tapping adds benefit beyond prayer, or whether their combination works differently according to religious commitment, cultural context, and personal preference.

Major clinical guidance continues to recommend established trauma-focused interventions for PTSD, while EFT remains a research question in NICE guidance last reviewed on April 8, 2025.

This position does not require rejection of SEFT. It requires proportionate claims.

The Technique Is Not the Person

A common risk in structured methods is that the procedure becomes more important than the individual. The practitioner may concentrate on selecting the correct point, phrase, or number of rounds while failing to notice that the participant feels pressured, confused, spiritually uncomfortable, or emotionally overwhelmed.

Ethical practice reverses this priority.

The person determines:

- whether to participate;
- which concern to address;

- how much to disclose;
- whether spiritual language is included;
- whether to continue;
- what action follows.

The procedure must be adapted to the person, not the person forced into the procedure.

Emotional Relief Is Not the Final Goal

A lower distress rating may be useful, but emotional relief alone does not determine whether a session has been successful.

A person may feel calmer and still need to:

- attend a medical appointment;
- apologies;
- establish a boundary;
- report abuse;
- revise a manuscript;
- seek legal advice;
- complete rehabilitation;
- obtain psychiatric care;
- accept that reconciliation is unsafe;
- make a difficult but responsible decision.

SEFT is most useful when regulation supports action.

The appropriate final question is not only:

“How do I feel now?”

It is also:

“What does integrity, safety, evidence, and responsibility require from me now?”

Spirituality Without Coercion

Spirituality can offer meaning, hope, patience, connection, forgiveness, humility, and trust. It can also become a source of guilt, fear, punishment beliefs, or institutional injury.

A spiritually sensitive practitioner does not assume that prayer is always comforting. The practitioner asks.

They do not declare the divine meaning of illness, trauma, rejection, or bereavement. They do not claim that failure to improve reflects weak faith. They do not use surrender to promote silence or tolerance of abuse.

Healthy spiritual integration allows honesty:

“I believe, and I am afraid.”

“I pray, and I remain confused.”

“I trust God, and I still need medical care.”

“I may forgive, and I may maintain a boundary.”

“I surrender the final outcome, and I continue to act responsibly.”

These statements preserve spiritual depth without denying human complexity.

Evidence without Contempt

Scientific caution should not become contempt for participants who report benefit. Personal experiences deserve respectful listening.

At the same time, personal testimony cannot replace controlled evidence. A convincing story cannot establish:

- mechanism;
- general effectiveness;
- medical cure;
- long-term recovery;
- superiority to established treatment.

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Professional integrity requires the ability to say:

“This may help.”

“We do not yet know.”

“Another treatment has stronger evidence.”

“This concern is outside my competence.”

“The technique did not produce a meaningful change.”

Uncertainty is not professional weakness. It is part of trustworthy care.

A Responsible Future for SEFT

The future of SEFT depends on more than increased promotion. It requires:

- clear intervention manuals;
- credible professional training;
- supervision;
- cultural and spiritual competence;
- transparent consent;
- rigorous trials;
- independent replication;
- active comparison conditions;
- adverse-event reporting;
- long-term follow-up;
- publication of negative findings.

Research should follow contemporary reporting standards. CONSORT 2025 now includes a 30-item checklist and participant-flow diagram intended to improve the completeness and transparency of randomized-trial reporting.

SEFT research should also ask questions beyond symptom reduction:

- Does it improve daily functioning?
- Does it support treatment adherence?
- Does it reduce or increase spiritual guilt?
- Is it acceptable to people who do not share the practitioner's faith?
- Does it help more than prayer or standard EFT alone?
- Which individuals do not benefit?
- What harms can occur?
- When should the method not be used?

Final Reflection

SEFT is best understood as a developing, complementary practice. It may help some people approach emotional experience with greater awareness, self-compassion, spiritual meaning, and behavioral choice.

Its responsible use requires four commitments:

Honesty

Acknowledge what the person is actually feeling.

Safety

Do not use tapping to delay protection, treatment, or referral.

Humility

Do not claim more than training or evidence permits.

Responsibility

Translate emotional regulation into appropriate action.

The mature practice of SEFT does not promise freedom from every painful emotion.

It supports a different form of freedom:

The ability to experience emotion without being completely controlled by it; to draw upon spirituality without denying reality; to accept the present without abandoning change; and to act with greater clarity, dignity, and responsibility.

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