Session 7

EFT – the Emotional Freedom Technique

Check-in:

1. Share two items from your gratitude journal
2. Connections between sleep and pain or something you have noticed about sleep
3. Any cognitive distortion you have noticed? How did you label/address them?

Affirmations

Sleep and Pain, Part 2

Medication Check

Homework:
Relaxation response Exercise 20 minutes per Day
Pain Diaries and Feedback Form
Write 3 things in your gratitude journal each day
Track your sleep

**REMINDER: No group in 2 weeks – we meet next December 10.

And check in with your buddy!

And if tonight my soul may find her peace
in sleep, and sink in good oblivion,
and in the morning wake like a new-opened flower
then I have been dipped again in God, and new-created.
~D.H. Lawrence

A good laugh and a long sleep are the best cures in the doctor's book. ~Irish Proverb

Sleeping is no mean art: for its sake one must stay awake all day. ~Friedrich Nietzsche

EFT – Emotional Freedom Technique

The Emotional Freedom Technique is a self-help technique in energy psychology, which has been studied and shown to aid in the treatment of depression, anxiety, pain and PTSD.

Here's how a basic Tapping sequence works:

- Identify the problem you want to focus on. It can be general anxiety, or it can be a specific situation or issue which causes you to feel anxious.
- Consider the problem or situation. How do you feel about it right now? Rate the intensity level of your anxiety, with zero being the lowest level of anxiety and ten being the highest.
- Compose your set up statement. Your set up statement should acknowledge the problem you want to deal with, then follow it with an unconditional affirmation of yourself as a person.

"Even though I feel this _____, I deeply and completely accept myself."
e.g. "Even though I'm feeling this anxiety about money, I deeply and completely accept myself."

Repeat the set up statement three times aloud, while simultaneously tapping the Karate Chop point or the Sore Spot.

Then tap 5-7 times on the points below with fingertips. As you tap on each point, repeat a simple reminder phrase, such as "my anxiety" or "my interview" or "my financial situation." Start at the top and work down, then finish by coming back to the top of the head.

Head (TH)
The crown, center and top of the head.
Tap with all four fingers on both hands.

Eyebrow (EB)
The inner edges of the eyebrows, closest to the bridge of the nose. Use two fingers.

Side of eye (SE)
The hard area between the eye and the temple. Use two fingers. Feel out this area gently so you don't poke yourself in the eye!

Under eye (UE)
The hard area under the eye, that merges with the cheekbone. Use two fingers, in line beneath the pupil.

Under nose (UN)
The point centered between the bottom of the nose and the upper lip. Use two fingers.

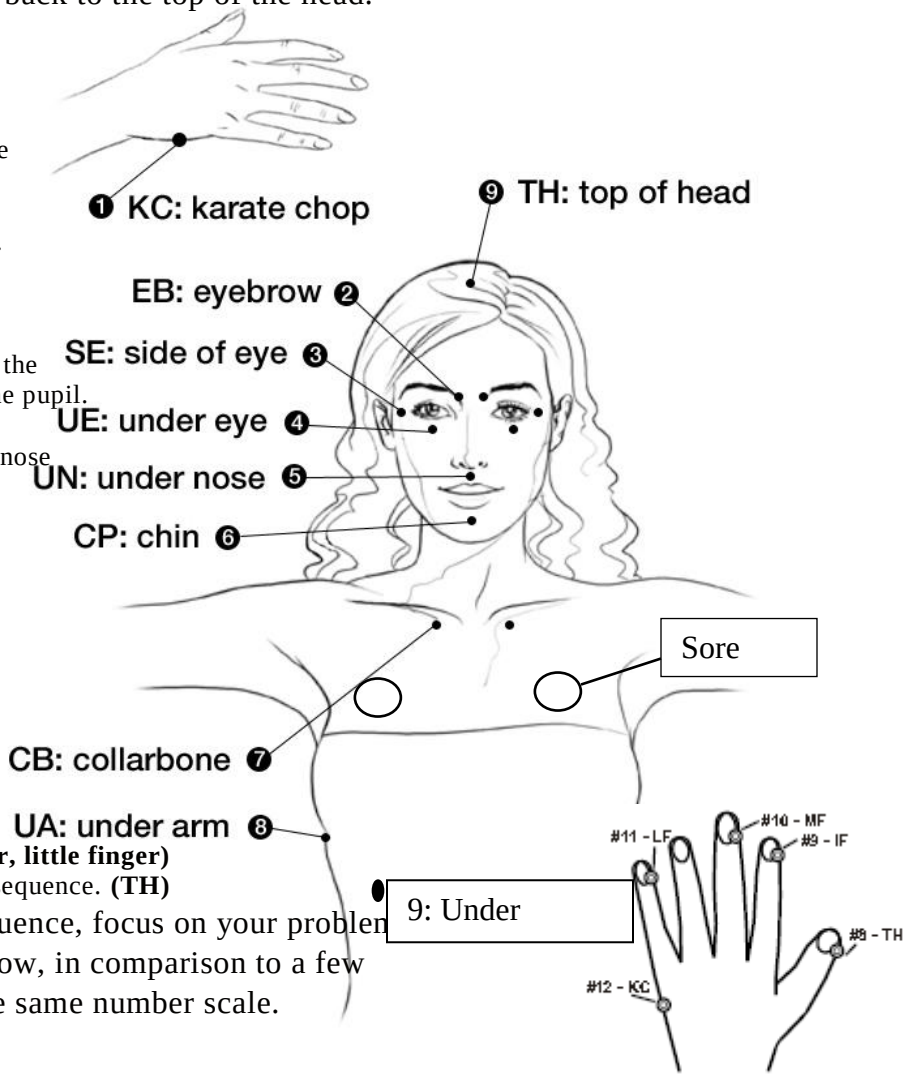
Chin (CP)
This point is right beneath the previous one, and is centered between the bottom of the lower lip and the chin.

Collarbone (CB)
Tap just below the hard ridge of your collarbone with four fingers.

Underarm (UA)
On your side, about four inches beneath the armpit. Use four fingers.

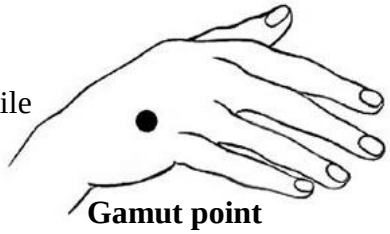
Under nipple – additional optional point

Fingers (Thumb, index finger, middle finger, little finger)
And back where you started, to complete the sequence. **(TH)**



- Now that you've completed the sequence, focus on your problem again. How intense is the anxiety now, in comparison to a few minutes ago? Give it a rating on the same number scale.

- If your anxiety is still higher than "2", you can do another round of tapping. Keep tapping until the anxiety is gone. You can change your set up statement to take into account your efforts to fix the problem, and your desire for continued progress. "Even though I have some remaining anxiety, I deeply and completely accept myself." "Even though I'm still a little worried about this interview, I deeply and completely accept myself." And so on.


Gamut point

Gary Craig adds the following:
The 9 Gamut Procedure: Continuously tap on the Gamut point while performing each of these 9 actions:
(1) Eyes closed (2) Eyes open
(3) Eyes hard down right (4) Eyes hard down left
(5) Roll eyes in circle (6) Roll eyes in other direction
(7) Hum 2 seconds of a song (8) Count to 5 (9) Hum 2 seconds of a song.

If this is not working, try:
1. Collarbone Breathing Exercise. Place two fingers of your right hand on your right Collarbone Point. With two fingers of your left hand, tap the Gamut point continuously while you perform the following five breathing exercises:
1. Breathe all the way in and hold it for 7 taps.
2. Breathe halfway out and hold it for 7 taps.
3. Breathe all the way out and hold it for 7 taps.
4. Breathe in halfway and hold it for 7 taps.
5. Breathe normally for 7 taps.
Next, bend the fingers of your right hand and place the knuckles on the right Collarbone Point and repeat. Repeat again by placing the right knuckles on the left Collarbone Point.
Then repeat the entire procedure with the fingertips and knuckles of the left hand.

2. **Energy toxin avoidance method #1**: Move from where you are. Sometimes there is something in your immediate environment that is causing the problem. It could be an electronic device such as a computer or TV or it could be fumes from a plant, carpet, or ventilation system. Perhaps you have some sensitivity to the chair in which you are sitting, or maybe the room you are occupying has been newly painted. So just the physical act of changing where you are can remove you from some offending item. You might want to stand up and go elsewhere in the room. If that fails, go to another room or go outdoors. Since EFT takes so little time to perform, you can move to several different places and try it out. If you find success with EFT after moving, then it is likely you have removed yourself from some toxin to your energy system.

3**. Energy toxin avoidance method #2:** Remove your clothing and take a thorough bath or shower without soap.

4. **Energy toxin avoidance method #3**: Wait a day or two. If methods #1 and #2 don't allow the result you are looking for then, chances are the energy toxins aren't on you. They are probably in you. This means that the toxins were ingested through eating, drinking, or inhalation.
Common energy toxins: Perfume, Refined sugar, Alcohol , Coffee, Nicotine, Wheat, Tea, Dairy, Corn , Caffeine, Pepper

Resources to learn more:
www.thetappingsolution.com www.emofree.com www.eftuniverse.com

Affirmations

A Definition: Telling yourself something good about yourself, whether you believe it or not, and sometimes in spite of evidence to the contrary.

A Rationale: Put simply, your brain doesn't know the difference between "a truth" and "a lie." It will "believe" whatever you tell it often enough and with enthusiasm. More appropriately, your conscious mind can program your subconscious mind; and your experience cannot be different than what you truly believe at the subconscious level.

Before You Begin: Decide what area of your life you want to work on and then decide what you want. There are several important points to know about affirmations:

- **Use the present or past tense**. Do not use the future tense. You want your mind to know it has already happened.
- **Be POSITIVE**. Use the most positive terms you can. Never use negatives in affirmations
- **Write them**. As you are learning to do affirmations, write them down so you will remember exactly what you want to say. Keep them short and very specific. Personalize them with your name.
- **Believe**. Always believe that what you are saying is happening. The more you believe, the stronger the affirmation.
- **Repetition**. Being repetitive and persistent helps to set them in your head and in your unconscious being.
- **Time**. Always have a specific time daily set aside for your meditations, affirmations and visualizations. This will help set a pattern for you so you will do them daily.

Suggested places for affirmation cards:

mirror in bathroom	dashboard of car	at your telephone
mirror on dresser	desk at office	bedroom door
closet door	desk at home	in books used at work/school
refrigerator door	in your wallet	
front door	in your brief case/backpack	

Affirmation word examples:

bright	capable	creative	strong
intelligent	beautiful	smart	giving
quick	peaceful	loving	hopeful
caring	responsible	successful	problem solver
calm	quiet	pretty	handsome
relaxed	enjoyable		

Some samples:

- I am at peace with the Universe
- I love and accept myself.
- I am safe and always feel protected.
- I acknowledge all of my feelings because I am in touch with my feelings.
- I am surrounded with loving, caring people in my life.
- I trust my inner being to lead me in the right path.
- I do all I can every day to make a loving environment for all those around me, including myself.
- My inner vision is always clear and focused.

Connie’s favorite: I don’t have to be perfect to be wonderful.

Affirmations for Health

- I have the power to improve my health.
- I am in charge of my health and wellness.
- I have abundant energy, vitality and well-being.
- I am healthy in all aspects of my being.
- I do not fear being unhealthy because I know that I control my own body.
- I am always able to maintain my ideal weight.
- I am filled with energy to do all the daily activities in my life.
- My mind is at peace.
- I love and care for my body and it cares for me.
- I will sleep easily tonight.

Affirmations for Peace and Harmony in your Life

- I am at peace with myself.
- I am always in harmony with the Universe.
- I am filled with the Love of the Universal Divine Truth.
- I am at peace with all those around me.
- I have provided a harmonious place for myself and those I love
- The more honest I am with those around me, the more love is returned to me.
- I express anger in appropriate ways so that peace and harmony are balanced at all times.
- I am at one with the inner child in me.

Affirmations for My Spirituality

- I am free to be myself.
- I am a forgiving and loving person.
- I am responsible for my own Spiritual Growth.
- My strength comes from forgiveness of those who hurt me.
- I am worthy of love.
- The more I love, the more that love is returned to me.
- I nurture my inner child, love her and have allowed her to heal.
- I am responsible for my life and always maintain the power I need to be positive and have joy.

General Affirmations

I am competent
I am strong
I am intelligent
I am beautiful
I am a good person
I am caring
I am loving
I am smart
I am creative
I am talented
I can lose weight
I can stop smoking
I can handle my children
I am letting go of fear
I am changing
I am positive
I am laughing and having fun
I am energetic
I am enthusiastic
I am relaxed
I am joyful
I am trusting
I am generous
I am courageous
I am forgiving
I am open
I am sharing
I can grow
I am healing
I am letting go of guilt
I am honest with my feelings
I am letting go of being compulsive
I am a problem solver
I am assertive
I deserve to love and to be loved.
I have solved problems like this before.
I have the ability to handle this.
I am responsible only for my own feelings.
I deserve to have my rights recognized.
I am a deserving human being.
I deserve to enjoy the fruits of my labor.
I grow in love daily.
I can handle all changes that come my way.
I like myself better each day.
I gain emotional strength each day.

Symptom Diary

Name _____

Full Circle Center for Integrative Medicine
4641 Valley East Blvd #2
Arcata, CA 95521-4630
707-840-4701
Fax 855-420-6321

	Describe situation	Physical Sensation (0-10) before meds	Physical Sensation (0-10) 45 min. after meds	Describe physical sensation	Emotional response (0-10)	Describe emotional response/thought	Action taken, including medications
Monday							
Date:							
Time 1:							
Time 2:							
Time 3:							
	Total:			Total:			Sleep: hours_____ Quality: _____
	Average:			Average:			
Tuesday							
Date:							
Time 1:							
Time 2:							
Time 3:							
	Total:			Total:			Sleep: hours_____ Quality: _____
	Average:			Average:			
Wednesday:							
Date:							
Time 1:							
Time 2:							
Time 3:							
	Total:			Total:			Sleep: hours_____ Quality: _____
	Average:			Average:			

	Describe situation	Physical Sensation (0-10)	Physical Sensation (0-10)	Describe physical sensation	Emotional response (0-10)	Describe emotional response/thought	Action taken, including medications
Date:							
Time 1:							
Time 2:							
Time 3:							
	Total:			Total:			Sleep: hours_____ Quality: _____
	Average:			Average:			
Friday:							
Date:							
Time 1:							
Time 2:							
Time 3:							
	Total:			Total:			Sleep: hours_____ Quality: _____
	Average:			Average:			
Saturday:							
Date:							
Time 1:							
Time 2:							
Time 3:							
	Total:			Total:			Sleep: hours_____ Quality: _____
	Average:			Average:			
Sunday:							
Date:							
Time 1:							
Time 2:							
Time 3:							
	Total:			Total:			Sleep: hours_____ Quality: _____
	Average:			Average:			

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FEEDBACK SHEET FOR HEALING GROUP

Name:_____ Date: ____/____/____

1) Please review your medication list and indicate any changes you have you made in your medications, supplements, or over the counter meds since the last group (i.e. stopped any, increased any, decreased any, added new ones).

_____

_____

What refills do you need today? _____

2) Have you had any injuries, events in your personal life, any nerve blocks, physical therapy, other treatments, exercise, etc. since our last group that made your pain worse or better? ☐ Yes ☐ No
If yes, please give details._____

_____

3) Over the past 2 weeks has your pain level:
☐ Decreased ☐ Stayed the Same ☐ Increased ☐ All over the place
What changes have you noticed? Please be as specific as you can:_____

_____

4) Rate your average pain score for the past 2 weeks:
NO PAIN 1 2 3 4 5 6 7 8 9 10 VERY SEVERE PAIN

5) Rate your pain score today:
NO PAIN 1 2 3 4 5 6 7 8 9 10 VERY SEVERE PAIN

6) Over the past 2 weeks has your emotional state:
☐ Decreased ☐ Stayed the Same ☐ Increased ☐ All over the place
What changes have you noticed? Please be as specific as you can:_____

_____

7) Rate your average mood for the past 2 weeks:
VERY SAD 1 2 3 4 5 6 7 8 9 10 VERY HAPPY

8) Do you address special nutritional needs as part of your healing plan? ☐ Yes ☐ No If yes, what nutritional goals are you addressing? _____

_____

9) For how long and how often did you do physical exercise in the past 2 weeks?
☐ Aerobic Time _____ How often? _____
☐ Stretching Time _____ How often? _____
☐ Strengthening Time _____ How often? _____

10) Did you meditate? ☐ Yes ☐ No How long? _____ How often?_____

11) Did you use other relaxation techniques or mini relaxation response exercises? ☐ Yes ☐ No
What did you do? _____ How often?_____

12) What goal did you set last time? _____
Did you accomplish it? ☐ Yes ☐ No If no, can you come up with a plan to help you succeed by identifying the obstacle and a solution to the obstacle?

Obstacle Solution

_____ _____

FUNCTIONAL IMPACT OF PAIN

13) Did you miss social events, work, or other appointments this month because of your health?
☐ Yes ☐ No What did you miss and why? _____

14) Indicate the word that describes how, during the past 24 hours, pain has interfered with your:

General activity	☐ Not at all	☐ Some	☐ Often	☐ Completely
Mood	☐ Not at all	☐ Some	☐ Often	☐ Completely
Ability to work (in or out of home)	☐ Not at all	☐ Some	☐ Often	☐ Completely
Interactions with other people	☐ Not at all	☐ Some	☐ Often	☐ Completely
Sleep	☐ Not at all	☐ Some	☐ Often	☐ Completely
Enjoyment of life	☐ Not at all	☐ Some	☐ Often	☐ Completely

15) What did you do for fun or pleasure this month? Or what gave you pleasure this month?_____
_____

16) Have you used any recreational drugs this month? _____

17) How many drinks of alcohol did you drink this week? _____ What kind? _____

18) How many cigarettes did you smoke this week? _____

19) How much caffeine did you drink this past week? _____ What kind? _____

20) How much candy, soda, or other sweets did you eat this past week? _____

21) The following could be medication side effects or from your underlying condition. Are you feeling/experiencing:

Symptom(s): Check box if present	**Medication(s) or other condition(s) you think caused it:**	**How did you deal with it:**	**Do you want suggestions?**
☐ Constipation:			☐ Yes ☐ No
☐ Difficulty sleeping:			☐ Yes ☐ No
☐ Dizzy, dopey:			☐ Yes ☐ No
☐ Nausea/vomiting:			☐ Yes ☐ No
☐ Difficulty waking in the morning:			☐ Yes ☐ No
☐ Loss of libido:			☐ Yes ☐ No

22) Any other physical complaints or questions you'd like your physician to respond to_____
_____
_____
_____

Can this be discussed in group? ☐ Yes ☐ No *If no, please ask physician if you should make an appointment.*
23) Any feedback or suggestions you would like to share with the staff? _____
_____