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David Feinstein

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Energy psychology uses cognitive operations such as imaginal exposure to traumatic memories or visualization of optimal performance scenarios—combined with physical interventions derived from acupuncture, yoga, and related systems—to induce psychological change. Although a controversial approach, this combination purportedly brings about, with unusual speed and precision, therapeutic shifts in affective, cognitive, and behavioral patterns that underlie a range of psychological concerns. Energy psychology has been applied in the wake of natural and human-made disasters in the Congo, Guatemala, Indonesia, Kenya, Kosovo, Kuwait, Mexico, Moldavia, Nairobi, Rwanda, South Africa, Tanzania, Thailand, and the United States. At least three international humanitarian relief organizations have adapted energy psychology as a treatment in their postdisaster missions. Four tiers of energy psychology interventions include (1) providing immediate relief/stabilization, (2) extinguishing conditioned responses, (3) overcoming complex psychological problems, and (4) promoting optimal functioning. The first tier is most pertinent in psychological first aid immediately following a disaster, with the subsequent tiers progressively being introduced over time with complex stress reactions and chronic disorders. This article reviews the approach, considers its viability, and offers a framework for applying energy psychology in treating disaster survivors.

**Keywords:** acupuncture; energy psychology; Emotional Freedom Techniques; hyperarousal; Thought Field Therapy; trauma

Energy psychology (EP), as most commonly practiced in clinical and postdisaster situations, is an exposure-based treatment. The effectiveness of exposure therapies with posttraumatic stress disorder (PTSD) and other anxiety disorders is well established. Exposure is, in fact, the single modality for which the evidence is sufficient to conclude, according to stringent scientific standards (National Institute of Medicine's Committee on Treatment of Posttraumatic Stress Disorder, 2007), that the method is an efficacious treatment for PTSD. Other treatments that have strong empirical support in treating PTSD, such as cognitive-processing therapy, stress inoculation training, and eye movement desensitization and reprocessing (EMDR), also usually incorporate substantial exposure components (Keane, Foa, Friedman, Cohen, & Newman, 2007).

From Innersource, Ashland, Oregon.

Address correspondence to: David Feinstein, Innersource, 777 East Main Street, Ashland, OR 97520; phone: 541-482-1800; e-mail: df777@earthlink.net.

In EP, as with other exposure-based treatments, exposure is achieved by eliciting—through imagery, narrative, and/or in vivo experience—hyperarousal associated with a traumatic memory or threatening situation. Unique to EP is that extinction of this association is facilitated by the manual stimulation of acupuncture or related points that are believed to send signals to the amygdala and other brain structures that quickly reduce hyperarousal. When the brain then reconsolidates the traumatic memory, the new association (to reduced hyperarousal or no hyperarousal) is retained. According to practitioners, this leads to treatment outcomes that are more rapid (less time, fewer repetitions) and more powerful (higher impact, greater reach) than the strategies used by other exposure-based treatments that are available to them, such as relaxation, desensitization, mindfulness, flooding, or repeated exposure. Another clinical strength reported by practitioners is increased precision and thus less chance of retraumatization. By being able to quickly reduce hyperarousal to a targeted stimulus, numerous aspects or variations of a problem may be identified, precisely formulated, and treated within a single session.

Although empirical validation for the effectiveness of using acupressure points in EP is still in a relatively early stage, striking treatment successes in the aftermath of severe trauma are being reported by a broad range of credible sources, giving the psychotherapy community cause to assess the method before conclusive research is available. This article offers a context for such inquiry as well as a framework for applying EP following natural and human-made disasters.

## Four Tiers of EP

The efficacy and mechanisms of EP have been matters of controversy (Feinstein, in press), and even as basic a question as whether EP is an isolated technique, equivalent for instance to systematic desensitization, or a more comprehensive psychotherapy, has been an area of confusion. A review of the major EP texts (e.g., Callahan & Trubo, 2002; Diepold, Britt, & Bender, 2004; Feinstein, 2004; Feinstein, Eden, & Craig, 2005; Gallo, 2002, 2004; Mollon, 2008) shows four tiers of EP interventions: providing immediate relief/stabilization, extinguishing conditioned responses, overcoming complex psychological problems, and promoting optimal functioning:

### Providing Immediate Relief/Stabilization

Much as a paramedic might instruct a patient having an anxiety attack to use a breath control technique that is incompatible with hyperventilation, EP uses in vivo interventions believed to be incompatible with limbic hyperarousal. Tapping on specified acupuncture points whose stimulation has been shown to decrease activation signals in the amygdala (Hui et al., 2000), for instance, appears to rapidly decrease elevated emotional responses in stressful situations. This simple procedure is proving to be a potent intervention for providing psychological first aid in the immediate aftermath of disaster.

### Extinguishing Conditioned Responses

Similar techniques are applied for extinguishing a maladaptive conditioned response, such as a phobia or irrational rage. EP exposure treatments target the response to internal or external cues that trigger dysfunctional fear, aggression, or avoidance. By eliminating the limbic hyperarousal caused by the triggering cue, associated problematic affective, cognitive, and behavioral patterns may be interrupted.

### Overcoming Complex Psychological Problems

An EP approach identifies and targets salient aspects of complex problems. Aspects of low self-esteem, for instance, might include unresolved memories of parental emotional abuse, self-defeating beliefs, exaggerated appraisals of interpersonal threat, and anxiety in social situations. The combination of acupoint stimulation with the mental activation of carefully selected scenes, feelings, or beliefs may be applied to the elements of a complex psychological problem, one by one.

### Promoting Optimal Functioning

Beyond its uses in helping people cope with and overcome psychological problems, EP interventions may be applied to alter self-concept, affect, and motivation in ways that promote confidence, optimism, courage, peak performance, social skills, and feelings of spiritual connectedness.

At the third and fourth tiers, EP is often integrated with other clinical or personal development approaches. In treating obsessive–compulsive disorders, for instance, strategies from cognitive behavior therapy (CBT) may provide a framework as EP techniques are used to rapidly reduce activation in response to specific cues. In enhancing personal resilience, strategies from Positive Psychology (such as the "building of buffering strengths" like perseverance or a capacity for pleasure, Seligman, 2002, pp. 6-7) may provide a framework as EP techniques are used to instill such strengths.

EP includes a variety of protocols (at least two dozen variations have been identified) that generally fall within the field of *energy medicine* (Feinstein & Eden, 2008), much as psychiatry is a specialty within conventional medicine. Energy medicine is recognized by the National Institutes of Health (NIH) as a form of complementary and alternative medicine that is based on the supposition that illness results from disturbances in the body's electromagnetic energies and energy fields (National Center for Complementary and Alternative Medicine of NIH, 2005). *Energy psychology* focuses on these energies for the purpose of alleviating psychological

problems and pursuing personal goals. The most well-known variations are Thought Field Therapy (TFT), the Emotional Freedom Techniques (EFT), and the Tapas Acupressure Technique (TAT). TFT is one of the earliest formulations of EP, developed in the 1980s by Roger Callahan. EFT is a streamlined variation of TFT that can be used by the general public outside clinical settings, originated by Gary Craig after studying with Callahan. TAT was developed by acupuncturist Tapas Fleming. All three use non-needle methods of stimulating acupuncture points (acupoints) to induce positive psychological change. TFT, EFT, and TAT have been by far the most widely used and investigated EP approaches and are the focus of this article.

## Controversies

As an approach whose procedures may look patently strange (such as tapping on the back of one's hand while humming a tune), whose explanatory models are derived from paradigms based in another culture, and whose advocates have made strong claims of efficacy without adequate research validation, EP has been exceedingly controversial among psychotherapists. Ray Corsini, editor of one of the few standard psychology texts to mention EP, explains his choice to include a chapter on such an "outlandish" approach by noting that TFT "is either one of the greatest advances in psychotherapy or it is a hoax" (2001, p. 689). The Continuing Professional Education Committee (CPEC) of the Education Directorate of the American Psychological Association (APA) developed a special regulation for EP that leans toward the "hoax" appraisal. Rather than following its usual procedure of having APA continuing education sponsors make their own determinations about a new approach according to established CPEC guidelines, the committee took the unprecedented step in 1999 of notifying its continuing education sponsors by a memo that they risked losing their sponsorship status if they offered APA continuing education credit for courses in TFT (Murray, 1999). This policy was still in effect at the time of this writing and had been broadened to include all energy psychology courses.

Nonetheless, the number of therapists incorporating energy psychology methods into their practices has been increasing steadily since the approach was introduced in the 1980s. *EFT Insights*, an e-newsletter that provides instruction on how to use EFT on a professional as well as self-help basis, had 368,000 active subscribers at the time of this writing, and this number was showing a net increase of more than 7,000 per month (G. Craig, personal communication, December 27, 2007). EP is increasingly recognized in Europe, with "Advanced Energy Psychology" qualifying as continuing education for psychologists, physicians, and related professions in several countries, including Germany, Austria, and Switzerland. An international professional organization, the Association for Comprehensive Energy Psychology (http://www.energypsych.org), was incorporated in the United States in 1999 and has developed a comprehensive certification program and ethics code. A review of one of EP's major texts (*Energy Psychology Interactive*; Feinstein, 2004) in the APA's online book review journal describes energy psychology as "a new discipline that has been receiving attention due to its speed and effectiveness with difficult cases" (Serlin, 2005). The review, by a former APA division president, notes that because EP successfully "integrates ancient Eastern practices with Western psychology [it constitutes] a valuable expansion of the traditional biopsychosocial model of psychology to include the dimension of energy."

## Evidence

Although the evidence is still preliminary and the number of randomized clinical trials limited, EP has reached the minimum threshold for being considered an evidence-based therapy, with EFT having met the APA Division 12 criteria as a "probably efficacious treatment" for specific phobias and with TAT having met the "probably efficacious" criteria for maintaining weight loss (Feinstein, in press). Imaginal exposure plus acupoint tapping was shown, for instance, to be superior to imaginal exposure plus diaphragmatic breathing in treating phobias of bugs and small animals (Wells, Polglase, Andrews, Carrington, & Baker, 2003). Three well-designed randomized clinical trials showed a single EFT session to be more effective than other treatment conditions in alleviating specific phobias; another showed EP to be effective for treating public speaking anxiety, another for test-taking anxiety, and another in weight control (reviewed in Feinstein, in press). Four additional randomized clinical trials surveyed in the same review reported statistical superiority in speed or effectiveness between EP and another treatment or wait-list condition, but experimental design flaws led the reviewer to categorize

each study as having limited generalizability. Two large exploratory outcome studies that did not use control conditions and were published without peer review (Andrade & Feinstein, 2004; Sakai et al., 2001) found EP to produce strong subjective improvement on a spectrum of anxiety disorders and a wide range of other nonpsychotic psychiatric conditions. Most research on EP, however, has been limited to anxiety-related disorders, and no randomized clinical trials have been conducted specifically in the treatment of disaster survivors.

Reports from the field, however, show a pattern of strong outcomes following the use of EP both immediately following disasters and in the subsequent treatment of PTSD. Hundreds of reports track the use of EP in the aftermath of wars and ethnic cleansing. Many of these accounts corroborate one another in terms of rapid relief and long-term benefits, yet the state of the art in applying EP following disasters still resides largely with the practitioners who have been carrying out such work. I interviewed eight EP practitioners who are associated with disaster relief organizations and engaged in e-mail dialogue with the leaders of three of those disaster relief organizations. The purpose of these interviews was to find where consensus exists among experienced practitioners regarding postdisaster uses of EP and also to collect anecdotal evidence from the field. Although such anecdotal reports are only a preliminary form of evidence, they are consistent and compelling enough to warrant attention. Several of these cases are posted at http://www.ed-em.com/ep-trauma-cases.htm.

In one report, the industrial coordinator for Pittsburgh's Critical Incident Stress Management team describes the psychological symptoms and rapid response to EP in a variety of workers who have been involved in the accidental deaths of colleagues and friends. In another report, a disaster worker who uses EP describes the almost instant amelioration of symptoms of shock with two women hospitalized for injuries sustained 3 days earlier during the 1998 bombing of the U.S. embassy in Nairobi. In a third, a social worker details the successful three-session treatment of debilitating PTSD symptoms with a woman who had been a close bystander during the World Trade Center bombings.

Carl Johnson, a clinical psychologist retired from a career as a PTSD specialist with the Veteran's Administration (VA), has for nearly 2 decades traveled frequently to the sites of some of the world's most terrible atrocities and disasters to provide psychological support using EP methods. About a year after NATO put an end to the ethnic cleansing in Kosovo, Johnson found himself in a trailer in a small village where the brutalities had been particularly severe. A local physician who had offered to refer people in his village had posted a sign that treatments for war-related trauma (nightmares, insomnia, intrusive memories, inability to concentrate) were being offered. Johnson described how, as a line of people had formed outside of the trailer, the referring physician told him, with some concern, that everyone in the village was afraid of one of the men who was waiting outside for treatment.

The others in the line had positioned themselves as far away from this man as possible. Johnson asked the physician to invite the man into the trailer. Johnson, who after a career in the VA is seasoned in working with war veterans, recalled that the man "had a vicious look; he felt dangerous." But he had come for help, so with the physician translating, Johnson asked the man to bring to mind his most difficult memory from the war. Everyone in the village was haunted by severe traumatic events, including torture, rape, and witnessing the massacre of loved ones. As the man brought the trauma to mind, his face tensed and reddened and his breathing quickened. Although he never put his memory into words, the treatment began. Johnson tapped on specific acupoints that he determined to be relevant to the trauma. He then instructed the man, through the interpreter, to do a number of eye movements and other simple physical activities designed to accelerate the process. Then more tapping. Within 15 minutes, according to Johnson, the man's demeanor had changed completely. His face had relaxed and his breathing normalized. He no longer looked vicious. In fact, he was openly expressing joy and relief. He initiated hugs with both Johnson and the physician. Then, still grinning, he abruptly walked outside, jumped into his car and roared away, as everyone watched perplexed.

The man's wife was also in the group waiting for treatment. In addition to the suffering she had faced during the war, she had become a victim of her husband's rage. The traumas she identified also responded rapidly to the tapping treatment. About the time her treatment was completed, her husband's car roared back to the waiting area. He came in with a bag of nuts and a bag of peaches, both from his home, as unsolicited payment for his treatment. He was profuse and appeared gleeful in his thanks,

indicating that he felt something deep and toxic had been healed. He hugged his wife. Then, extraordinarily, he offered to escort Johnson into the hills to find trauma victims who were still in hiding, too damaged to return to life in their villages, both his own people—ethnic Albanians—and the enemy Serbs. In Johnson's words, "That afternoon, before our very eyes, we saw this vicious man, filled with hate, become a loving man of peace and mercy." Johnson further reflected how often this would occur, that when these traumatized survivors were able to gain emotional resolution on experiences that had been haunting them, they became markedly more loving and creative. Although survivors, even after a breakthrough session like this, are still left with the formidable task of rebuilding their lives, the treatment disengaged the intense limbic response from cues and memories tied to the disaster, freeing them to move forward more adaptively.

The 105 people treated during Johnson's first five visits to Kosovo, all in 2000, had each been suffering for longer than a year from the posttraumatic emotional effects of 249 discrete, horrific self-identified incidents. For 247 of those 249 memories, the treatments (using TFT) successfully reduced the reported degree of emotional distress not just to a manageable level but to a "no distress" level (0 on a 0-10 SUD or "Subjective Units of Distress" scale, after Wolpe, 1958). Although these figures strain credibility, they are consistent with other reports (see below). Approximately three fourths of the 105 individuals were followed for 18 months after their treatments and showed no relapses—the original memory no longer activated self-reported or observable signs of traumatic stress (Johnson, Mustafe, Sejdijaj, Odell, & Dabishevci, 2001).

Johnson made a total of nine trips to Kosovo between February 2000 and June 2002. His later visits were as much to train local health care providers in TFT as to treat additional patients. The follow-up information on approximately 75% of the people he worked with during his first five visits came primarily from physicians who had identified traumatized individuals from their practices and participated as translators in the initial TFT treatments. Because these physicians continued to care medically for the individuals, they were able to provide follow-up on the TFT sessions. Their reports consistently suggested that once a memory had been cleared of its emotional charge, it remained clear, although other memories might subsequently be presented for treatment. The initial session, however, appeared to have durably neutralized the hyperarousal to the traumatic memories that were identified and to have markedly improved overall coping and sense of well-being. Reports of these outcomes came to the attention of the chief medical officer of Kosovo (the equivalent of the U.S. Surgeon General), Dr. Skkelzen Syla (himself a psychiatrist), who investigated them and subsequently wrote a letter of appreciation on January 21, 2001:

> Many well-funded relief organizations have treated the posttraumatic stress here in Kosova. Some of our people had limited improvement but Kosova had no major change or real hope until . . . we referred our most difficult trauma patients to [Dr. Johnson and his team]. The success from TFT was 100% for every patient, and they are still smiling until this day [and, indeed, in the follow-ups, each was free of relapse].

**Table 1.** Johnson's Tally of Energy Psychology Treatment Outcomes Following Disasters

| Country | No. of Clients | No. of Traumas Identified | No. of Traumas Resolved |
|---|---|---|---|
| Kosovo | 189 | 547 | 545 |
| South Africa | 97 | 315 | 315 |
| Rwanda | 22 | 73 | 73 |
| Congo | 29 | 78 | 77 |
| Totals | 337 | 1,016 | 1,013 |

Johnson kept a simple but ultimately provocative set of statistics during his visits to Kosovo and other areas of ethnic cleansing, warfare, and natural disasters. He tracked the number of people treated, the number of traumatic incidents identified, and the number of incidents where full relief was reported (i.e., hyperarousal to the traumatic memory was completely neutralized according to the person's subjective report). Table 1 shows his tally.

Johnson, who holds diplomate status with the American Board of Professional Psychology, acknowledges that such figures raise even his own skepticism. Although recognizing that "well-controlled research is essential before results like these can be accepted," he affirms that the figures accurately reflect his experiences and that he "recorded them exactly according to what happened." After interviewing Johnson, I interviewed several therapists who worked on these teams, and their reports corroborate Johnson's. Johnson emphasizes that reducing

the impact of traumatic memories with EP, as reflected in the above numbers, is not the end of a person's healing journey. "Often," however, "it is a new beginning," providing people an opportunity to rebuild their lives without the oppressive emotional weight of their traumatization. To this end, Johnson takes great care to integrate the EP treatment into the context of the local culture's values, social structure, family relationships, and healing traditions to support continued healing and follow-up.

As well as being corroborated by interviews with the therapists who worked with Johnson in Kosovo and in Africa, Johnson's reports are also consistent with what other disaster workers are describing. Clinicians from a wide range of backgrounds are reporting that EP treatments can rapidly clear much of the emotional overwhelm associated with traumatic memories. For example, 29 low-income refugees and immigrants living in the United States who were categorized as having the symptoms of PTSD based on having met a cutoff score on the Posttraumatic Checklist-C (PCL-C) reported significantly less avoidance, intrusive thoughts, and hypervigilance ($p < .05$ for each measure) after one to three sessions of TFT (Folkes, 2002).

Particularly poignant are reports that have been coming in from the TFT Trauma Relief Committee's work with an orphanage in Rwanda. Many of the children had seen their parents die by machete during the ethnic cleansing 12 years earlier and were reliving the horrors of the massacre of 800,000 Rwandans. Daily flashbacks and nightmares were common, as were bedwetting, depression, withdrawal, isolation, difficulty concentrating, jumpiness, and aggression. Standardized pretreatment and posttreatment tests for PTSD (translated into Kinyarwandan) were administered to 50 of these children (27 boys and 23 girls), ages 13 through 18, and a children's PTSD assessment tool for parents and guardians was administered to their caregivers. Treatment, provided in April and May 2006, generally involved 3 TFT sessions of approximately 20 min each. The tests were structured after DSM IV criteria for PTSD. Average symptom scores, based on both the tests taken by the children and the caregivers' observations about the children, substantially exceeded the cutoffs for a diagnosis of PTSD. Scores after the three sessions were substantially lower than the cut-offs. Retesting a year later showed that the improvements held. Immediate reductions in flashbacks, nightmares, and other symptoms were common. Details of these findings are being prepared for publication (C. Sakai, personal communication, March 7, 2008).

Lynn Garland, a social worker with the Veterans' Healthcare System in Boston, reports that she and numerous colleagues using EP in the VA are having "dramatic results in relieving both acute and chronic symptoms of combat-related trauma" (Feinstein et al., 2006, p. 17). Members of the Trauma Relief Team of the Association for Thought Field Therapy Foundation have used TFT while providing disaster response services in more than a dozen countries, with strong results, consistent with those in Table 1, being reported (N. Gairdner, personal communication, November 30, 2005). The Humanitarian Committee of the Association for Comprehensive Energy Psychology (ACEP) reports corresponding observations based on its work with some 300 tsunami victims in Southeast Asia (J. Hartung, personal communication, January 14, 2006). Although systematic follow-up was not conducted, the ACEP group—drawing from TFT, EFT, and TAT—describes strong, rapid responses to the psychological aftermath of the disaster, including alleviating anxiety, depression, anger, and physical pain, as well as the successful resolution of earlier traumatic memories activated by the tsunami experience.

TAT (http://www.tatlife.com) was also used following the 2006 earthquake in Indonesia, applied by local relief workers who were provided seminars in the method's disaster relief protocol. Widespread reports of rapid relief led to some 6,000 adults and children receiving the treatment in individual and group settings. TAT has also been used following other natural disasters. Ignacio Jarero, president of the Mexican Association for Crisis Therapy, reported (on the TAT Web site) the use of TAT with 1,652 children after natural disasters in Mexico, Nicaragua, Colombia, and Venezuela and its use as an adjunct to training with 642 frontline service personnel in those countries. He stated, "Children and adults reported significant reductions in SUDS at the completion of the protocol. . . . TAT is our favorite technique to reduce distress because it is easy to teach and apply."

The Green Cross (the Academy of Traumatology's humanitarian assistance program), which deploys counselors to disaster areas with a focus on alleviating the psychological consequences of trauma, is increasingly using EP methods. The program, founded in 1995 in response to the Oklahoma City bombings, has recently been working closely with the TFT Trauma Relief Team and the ACEP Humanitarian Committee to expand the number of available relief workers trained in EP methods. According to Green Cross founder Charles Figley, who also served as the

chair of the committee of the Department of Veteran Affairs that first identified PTSD, "Energy psychology is rapidly proving itself to be among the most powerful psychological interventions available to disaster relief workers for helping the survivors as well as the workers themselves" (C. Figley, personal communication, December 10, 2005).

## A Framework for Postdisaster Applications of Energy Psychology

A landmark international conference, organized with the intention of developing consensus on the best practices for early psychological interventions following mass violence, was held 6 weeks after the September 11, 2001, New York City bombings (although it had been scheduled long before that date). An anthology that reports on and continues the work initiated by the conference (Ritchie, Watson, & Friedman, 2006) provides consensual and evidence-based guidance to mental health workers on how to proceed in the wake of mass violence and other disasters. These reports were used in formulating the following clinical guidelines for applying EP in the aftermath of natural and human-made disasters. For context, also consider the UN Inter-Agency Standing Committee's (2007) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, a widely respected resource that includes 25 "action sheets" on how to implement a coordinated community response to mental health needs in the midst of emergencies.

### Immediate Responses to a Disaster

Beyond attending to basic needs such as safety, security, food, shelter, and medical problems directly following a disaster, psychological first aid is defined as "the use of pragmatic-oriented interventions delivered during the immediate-impact phase . . . to individuals who are experiencing acute stress reactions or who appear at risk for being able to regain sufficient functional equilibrium by themselves, with the intent of aiding adaptive coping and problem-solving" (Young, 2006, p. 134).

Active psychotherapies that elicit emotional processing or detailed trauma narratives are generally not recommended immediately following a disaster, with the unanticipated negative effects of critical stress debriefing often being cited (Litz, Gray, Bryant, & Adler, 2002). Debriefing did not prevent vulnerable individuals from subsequently developing PTSD, inadvertently pathologized normal stress reactions, and sometimes interfered with people's natural coping mechanisms. Some individuals are better served by a period of denial so they can rest and recover emotionally before attempting to process a severe trauma. Early interventions may open previous unresolved traumas during a period when the individual is least equipped to reconsolidate them. Some early interventions have also coerced individuals who are uneasy about disclosing personal information into sharing in ways that have negative consequences on their sense of self-worth as well as on their ongoing relationships with coworkers who might be involved in these disclosures.

EP interventions, however, incorporate strategies that practitioners claim mitigate these concerns. Jim McAninch, of Pittsburgh's Critical Incident Stress Management (CISM) team, is often on the scene within hours following accidents that involve fatalities. The mandate of the CISM team includes facilitating the "normal recovery process of normal people having normal, healthy reactions to abnormal events." Like most community disaster response programs, McAninch's team is explicitly *not* meant to provide psychotherapy or to substitute for psychotherapy, yet its stated goals include therapeutic objectives that would fall within the parameters of psychological first aid and other early mental health interventions. McAninch's administrative supervisor was at first highly skeptical about the use of EP as part of the CISM disaster response. However, enough instances have now been logged in which TFT was judged to have brought about rapid and striking results in facilitating the emotional recovery of survivors of events involving fatalities that McAninch has been asked to provide TFT training to the entire Pittsburgh CISM team.

McAninch typically has those who were directly involved in the accident recount or mentally replay what they witnessed, sometimes one on one and sometimes with other witnesses and survivors. While focusing on difficult memories or feelings, the person is simultaneously tapping on acupoints that purportedly reduce arousal. McAninch notes that his team handles accidental deaths and injuries in which survivors, in addition to processing the recent event, often find that unresolved traumas from the past are activated. Treating these, again by stimulating acupoints while the memory is actively engaged, helps the present traumatic incident, in McAninch's experience, to be more easily and rapidly resolved (J. McAninch, personal communication, May 5, 2007).

This use of a readily available technique that quickly decreases arousal is a critical difference between EP and debriefing or other interventions that might ask a person to recount a trauma within days after it occurred. Sophia Cayer, an EFT practitioner who worked with hurricane evacuees in Alabama following Hurricane Katrina, explains, "The difference is that with EFT, even if it is only a single session, it doesn't leave the person stranded. It is not a matter of just soothing them and then letting them go. They are given powerful tools they can regularly use as they move through the crisis and beyond" (S. Cayer, personal communication, December 1, 2005).

For instance, Barbara Smith, a trauma specialist who works for a government-funded agency in New Zealand, often takes the official report of a person who has been recently traumatized (Carrington, 2005). She needs the people she interviews to recall and recount their traumatic experiences in detail to complete the necessary paperwork. Because some of them are still in deep shock from the recent incident or from earlier trauma that has been reactivated, and many re-experience the horror and overwhelming effects of the traumatic event in talking about it, it may take up to four sessions to complete a single report. Even then, the reports might not always be clear or coherent. By simply introducing tapping and having her clients continuously tap specific acupoints while recounting their painful experiences, Smith has found that "the time it takes to collect the crucial information is more than cut in half [and] the reports themselves are more coherent and accurate." She adds that as a side benefit, these trauma victims "learn how to calm themselves from the very first session" (Carrington, 2005).

Smith's use of EP is consistent with the way other practitioners report applying it within the first days or weeks following a trauma. Although aggressive probing or invasive uncovering techniques are generally not used by EP practitioners immediately following a disaster, EP is often applied to memories and thoughts that the client is already expressing or actively ruminating on. Rather than a complete EP protocol, the tapping techniques that are most effective for reducing arousal are taught on a psychological first aid basis (first tier—providing immediate relief/stabilization).

These techniques can be introduced in a simple and matter-of-fact manner. Young (2006, p. 143) provides a 30-second approach for introducing diaphragmatic breathing, gently using words such as: "Everyone feels overwhelmed now, how about we take a few slow deep breaths" [along with a demonstration of diaphragmatic breathing]. This could be followed by suggesting, "Let's add to this now some tapping on stress release points. Just tap where I tap" (first tier—providing immediate relief/stabilization). Intrusive images, previous memories activated by the trauma, and the affect produced by cognitive distortions may also be the focus while points that reduce arousal are tapped (second tier—extinguishing conditioned responses).

Demonstrating how to self-stimulate acupoints that reduce arousal provides a straightforward tool for emotional self-management that, according to EP practitioner reports, is quick, effective, and generally as safe as other relaxation techniques (Young, 2006, pointed out that in rare cases, any form of relaxation technique may increase anxiety, intrusive images, or dissociative states). Because tapping acupoints, when properly introduced and applied, is relatively noninvasive, even if it does not produce the desired effects, no harm is done by the physical procedure as such. Summarizing his experiences as a member of the TFT Trauma Relief Team providing postdisaster EP services in Kosovo, Rwanda, the Congo, and New Orleans, Paul Oas observed: "Safety, food, and shelter come before emotional healing, but even under dire circumstances, you can use the tapping procedures to calm people who are hysterical" (P. Oas, personal communication, November 20, 2005).

## Interventions 1 to 4 Weeks After Exposure to a Trauma

After the initial phase of shock and disorientation, mental health interventions between 1 and 4 weeks following the disaster have different goals "and employ different strategies than responses that typically occur in the initial days after trauma exposure" (Bryant & Litz, 2006). Although managing stress reactions is still a prominent concern, focus shifts to identifying individuals who are at greatest risk of chronic mental health problems and deciding how to use inevitably scarce mental health resources most effectively.

EP treatments in the weeks following a trauma can continue to focus on lowering anxiety levels, countering intrusive thoughts and images, reducing arousal to previous memories activated by the trauma, and addressing the affect that induces cognitive distortions (second tier, extinguishing conditioned responses). Although a single EP session is,

according to practitioner reports, often effective for work at this level, the option of appropriate follow-up or referral should be ensured with individuals showing signs of vulnerability to chronic PTSD or other psychological disorders.

A reported strength of EP in reducing symptoms of acute stress is that it can be efficiently taught as a self-soothing technique in group settings. Participants are also able to experience immediate relief without, as contrasted with debriefing, having to reveal to other group members specific memories or emotions. In one variation, the practitioner works with a volunteer in front of the group. At the same time, the group is instructed to self-apply some of the procedures being used with the volunteer, focusing on the volunteer's psychological distress rather than on their own. A reduction in the emotional intensity of issues that audience members had previously identified is subsequently reported by a large proportion of the group.

Although no studies have been conducted on the use of this technique in postdisaster situations, there is some evidence for its efficacy with a general population. A within-subjects design was used with 102 participants who attended either of two 3-day EFT workshops open to the general public (Rowe, 2005). The participants were given a well-established, standardized symptom checklist (the Derogatis Symptom Checklist, short form) 1 month prior to the workshop, immediately prior, immediately after, 1 month after, and 6 months after the workshop. No significant difference was found in the mean test scores 1 month prior to and immediately prior to the workshop. Following the workshop, a highly significant decrease ($p < .0005$) was found on the checklist's global measure of psychological distress as well as all nine subscales, and these improvements held at the 6-month follow-up. Although the mechanisms for such outcomes are still unknown, practitioners consistently describe this finding, and reported applications following disasters seem encouraging.

For instance, about a month following Hurricane Katrina, Roseanna Ellis, an EFT practitioner, and three of her colleagues were asked by the pastor of a small church in Selma, Alabama, to work with his congregation, which was hosting a number of displaced hurricane survivors. Prior to extending this invitation, the pastor had experienced marked relief from symptoms of compassion fatigue as well as from some longstanding personal challenges during a single EFT session with Ellis.

The church held a Wednesday evening "family night," and Ellis and her team were invited to attend it to introduce EFT. Of 30 people in attendance, 13 were evacuees; the others were regular members of the church. After the pastor gave a brief introduction, explaining the framework for the evening, the four practitioners took a role in the presentation. One explained the theory of stress, one introduced EFT, another described its history, and the fourth demonstrated the tapping points. Then the practitioners worked with individuals in front of the group, one at a time. During the course of the 2-hr meeting, each practitioner worked with two or three people. Each demonstration subject was treated for between 10 and 20 min.

A 52-year-old woman, for instance, who had been forced from her home, tearfully made each of the following statements and rated each as a 10 on the 10-point SUD scale: "I feel lost; I feel displaced; I feel confused and unfocused; I feel angry; I feel all alone; I feel I have no place in this whole world that I can call my home; No one knows where to reach me because they keep moving us from place to place." At the end of 20 min, focusing on these one at a time, she appeared calm and in control, reporting that her distress level with each statement was now at 0 of 10. She stated, "I have the world to choose from for my next home. . . . I have always wanted to write my life story and was afraid to, but now I am ready. . . . I could have died like some of my friends, but God saved me for a purpose. . . . Maybe Katrina was the end of my old life and a renewed beginning."

Before the stage work, each audience member identified a personal area of emotional distress and rated it from 0 to 10. They then put their own issues aside as the demonstrations were conducted. But with each person on the stage, the audience self-applied the same procedures being used by the person on the stage. If the person on stage was tapping a set of acupoints while stating, "feeling displaced," the audience was doing the exact same tapping and making the exact same statement. Known as "borrowing benefits" (Rowe, 2005), this method is repeatedly reported to reduce the distress level for the original issue identified by a vast majority of audience members, even if no treatment focuses specifically on the personal issues the audience members had selected earlier. And indeed, every person in the audience at the church indicated at the end of the evening that the initial distress level they had identified had decreased when they again tuned into their

original issue. Describing the value of using this approach with a group of people who have shared the same trauma, Ellis noted, "Everyone can relate to the shock, grief, anger, displacement, and fear of the unknown. Then seeing other people quickly calm themselves gives hope. And feeling your own emotions rapidly easing is the start of healing" (R. Ellis, personal communication, December 2, 2005).

### Interventions After the First Month

Raphael and Wooding (2006) described a "honeymoon period" shortly after a disaster, during which there is intense affiliative behavior, convergence of support, and public acknowledgement of heroism and suffering." This phase may, however, over time "merge into angry protest and disillusionment and demoralization, then progressive recovery and renewal" (p. 175). By a month following the disaster, "the impact of loss of human life, injury, and destruction of physical and social resources should be fairly clearly defined" (p. 177). Individuals who may be in need of longer term treatment can be identified. Particularly vulnerable are those who are bereaved, who are injured, whose acute stress symptoms persist, who were most severely exposed to the disaster, whose physical and social resources have been destroyed, who have been previously traumatized, who had preexisting mental illness or physical disabilities, and who served as emergency responders.

As with CBT, EP uses cognitive restructuring in conjunction with its exposure methods. Mollon, in fact, asserted that EP is not an *alternative* to CBT but rather a "crucial additional component that greatly enhances its efficacy," providing more effective means for "affect regulation, desensitisation, and pattern disruption" (2008, p. 619). Pessimistic appraisals, avoidance strategies, and self-limiting beliefs about self, world, and future—all common consequences of traumatic events—are amenable to restructuring when the affect triggered by traumatic memories and anticipated analogous situations is significantly reduced. In addition, a tapping protocol for "neutralizing negative core beliefs and for instilling positive ones" (Gallo, 2004, p. 181) has been found effective by EP practitioners. Whether a practitioner and client are focusing on a traumatic memory that is tied to maladaptive cognitions or addressing a belief that contributes to pessimism and hopelessness, reducing hyperarousal and engaging in cognitive restructuring are natural counterparts of an EP approach.

Those who worked with the Kosovo, Rwanda, Congo, and South Africa survivors described in Table 1 assert that decreasing arousal to the most horrific memories of civilian survivors of warfare and ethnic cleansing produced global improvements in the person's ability to function. Although the only systematic outcome information available from these interventions is based on the impressions of the physicians who continued to medically care for approximately three fourths of the first 105 people to receive TFT in Kosovo, plus the informal investigation by Kosovo's chief medical officer, these assessments are encouraging. Asked how he determines whether a treatment for a traumatic event has been successful, Carl Johnson replied: "It has been successful when there is no suffering or anguish upon recalling the event. But at the same time, there is no reduction in sensitivity, distortion of values, or impairment in the ability to love. The memory is retained, but it is no longer in neon. There is still an awareness of the horror of the event, but it no longer has its grip on the person's soul. Where the memory had controlled the person, now the person has control of the memory."

Other reports of brief EP treatments following dire events corroborate the viability of a strategy whose focus is to rapidly reduce the hyperarousal associated with traumatic memories, disturbing ruminations, and negative appraisals. For instance, a team of 12 TFT practitioners from eight states were invited by three medical and social service organizations in New Orleans to provide treatment and training to their staffs 4 months following Hurricane Katrina (H. Ayers, personal communication, January 30, 2006). These medical and social service personnel were inevitably victims of the disaster as well as helpers, and the strategy taken was to make their treatment part of their training. A total of 161 participants received treatment and training at six different sites. Written evaluations were obtained from 87 of the participants. Of these, 86 stated that they experienced positive changes and/or elimination of the problems they were experiencing at the time. Data compiled by Caroline Sakai on the 22 participants she treated showed that their presenting complaints included anger, anxiety, depression, eating in order not to feel, frustration, guilt, survivor guilt, hurt, loss, loss of control, need for improved performance, overwhelming feelings, panic, physical pain, resentment, sadness, shame, stress, traumatization, and worry. Each problem area was given a 0 to 10 SUD rating. Before treatment, the average (mean) score for the 51 problem areas described by

the 22 clients was 8.14. After treatment, usually consisting of a single individual session of less than 15 min (which followed a half-hour group orientation), it was down to 0.76.

Long-term treatment of PTSD and other psychological damage following disaster experiences typically involves more than healing traumatic memories, reducing hyperarousal, and transforming negative beliefs. Lifelong psychological and behavioral patterns may be examined, relationships may be transformed, and social involvements may radically shift during the reorientation process that follows the destabilization caused by severe trauma. The term *posttraumatic growth* has been coined to describe the greater resilience and higher level of functioning that ideally are outcomes of traumatic experiences. A study of the long-term impact of the most traumatic life experiences of 83 elders (average age 77.9) suggested that "post-traumatic growth from events that occurred even many years earlier may have favorable influences on subsequent coping, death attitudes, and adjustment to recent stressors" (Park, Mills-Baxter, & Fenster, 2005, p. 297). Although posttraumatic growth appears to be a natural adaptation that frequently occurs, the clinician's awareness of this organic tendency can help in supporting it.

EP may be combined with additional components of CBT as well as with methods from depth psychotherapy (Mollon, 2008) in addressing the demanding psychological challenges many people face following a severe traumatic experience (third tier—overcoming complex psychological problems). In addition, methods that enhance confidence, optimism, courage, performance, social skills, and feelings of spiritual connectedness (fourth tier—promoting optimal functioning) are often useful at this time. Larger existential questions may also need to be addressed, such as "Why did I survive?" when loved ones or others were lost. As Shalev (2006) noted, most therapies tackle negativity rather than to explicitly foster positive emotions, but it is the desire for life that ultimately motivates survivors—whose shock, despair, and depression may be overwhelming—to recover: "We regularly address survivors' negativism, hoping that once the grip of such emotions loosens, the desire for life will put the trauma back into its right place as interference with life rather than life-defeating occurrence" (p. 118).

## Avoiding Inadvertent Harm

Even an approach as widely endorsed by the professional community as debriefing had competent therapists leaving unrecognized harm in their wakes. Although there is no controlled research on EP following its use in disaster areas, preliminary indications about potential harm are available. At the most basic level, no incidents where harm was done were identified, in response to direct questioning, during the inquiries conducted for this article with the members and leadership of the three major organizations (the Green Cross, the TFT Trauma Relief Committee, and the ACEP Humanitarian Committee) using EP interventions in disaster areas. In each case that a team went into a disaster area, beyond the team's own case reports and outcome evaluations, local observers in positions of authority offered—whether formally or informally—strikingly positive postdeployment assessments, most often with invitations or appeals for return visits.

According to spokespersons for the Green Cross, the TFT team, and the ACEP team, local follow-up, such as by the physicians who stayed in contact with the survivors treated in Kosovo, has consistently indicated that the benefits of the treatment are lasting and the treatment did not result in reports that would lead to concerns about unintended harm. Often, in fact, the communications from local observers indicated surprise and appreciation that the EP interventions were so unexpectedly superior to other approaches.

These sentiments are evident, for instance, in the letter cited earlier from the chief medical officer of Kosovo and the following, from a letter expressing appreciation and an invitation to return, written by Dwayne Thomas, MD, chief executive officer of the Medical Center of Louisiana at New Orleans. The letter, which was sent to members of the TFT Trauma Relief Team about a month after their first visit to New Orleans following Katrina, mentions other treatments that had been used by the hospital and then observes: "The overwhelmingly positive response to the [TFT] therapy was a welcome and delightful surprise for us all."

## Conclusions

Strong anecdotal reports about the efficacy of EP have been accumulating for more than 20 years from a spectrum of credible sources, and a growing number of controlled comparison studies are promising (Feinstein, in press). Increasing numbers of psychotherapists have applied EP in emergency and postdisaster settings and reported that it appears to be an effective tool for rapidly reducing hyperarousal, managing stress, and overcoming a wide

range of affect-related disorders. It also integrates well into other protocols, such as CBT, for long-term healing of those who are most seriously damaged by their experiences during a disaster. Although we are still learning about the power, limitations, and best applications of the approach, the purported ability of EP to rapidly reorganize the emotional and behavioral disruption that occurs for many people in the aftermath of severe trauma establishes it as a potential resource worthy of serious attention by those charged with the care of disaster survivors.

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