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Controversies in Energy Psychology

David Feinstein, Ph.D.
Ashland, Oregon

Abstract

In the quarter century since tapping on acupuncture points was introduced as a method psychotherapists could use in the treatment of anxiety disorders and other emotional concerns, more than 30 variations of the approach have emerged. Collectively referred to as "energy psychology" (EP), reports of extraordinary speed, range, and durability of clinical outcomes have been provocative. Enthusiasts believe EP to be a major breakthrough while skeptics believe the claims are improbable and certainly have not been substantiated with adequate data or explanatory models. Additional controversies exist among EP practitioners. This paper addresses the field's credibility problems among mental health professionals as well as controversies within EP regarding a) its most viable explanatory models, b) its most effective protocols, c) how the approach interfaces with other forms of clinical practice, d) the conditions it can treat effectively, e) what should be done when the method does not seem to work, and f) how the professional community should respond to the plethora of practitioners who do not have mental health credentials.

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In the first randomized controlled trial using energy psychology (EP) with post-traumatic stress disorder (PTSD), 16 of 19 veterans, all of whom exceeded the PTSD cutoff score on the military version of the Post-Traumatic Stress Checklist before treatment, were no longer within the PTSD range after 6 one-hour sessions (Church et al., 2009). Mean scores decreased from 60.5 to 36.8 (the PTSD cutoff is 50) while scores for a waitlist control group remained essentially unchanged. These findings are corroborated by earlier outcome studies with both veterans (Church, in press; Church, Geronilla, & Dinter, 2009) and with disaster victims (Feinstein, 2008b). Preliminary findings with adolescents have been even more encouraging, with a *single* session of EP reliably reducing scores on standardized tests from above to below PTSD cutoffs in two independent studies (Church, Piña, & Reategui, 2009, $p < .05$ with 8 subjects; Sakai, 2007, $p < .0001$ with 50 subjects).

Meanwhile, in one of the strongest studies demonstrating the efficacy of Cognitive Behavior Therapy (CBT), widely considered the "treatment of choice" for PTSD (Bryant, 2008, p. 555), 60 percent of subjects still met the criteria for PTSD after 12 sessions and 50 percent showed no symptom relief at all (Monson et al. 2006), a finding that is consistent with other CBT studies (Barlow, Allen, & Choate, 2004; Bryant, 2008). Noting such contrasts, a small but growing number of clinicians have enthusiastically embraced EP, and the approach has also become somewhat of a pop psych phenomenon. More than 1.2 million people have downloaded *The EFT Manual* (http://emofree.com), a guide for the back-home application of the Emotional Freedom Techniques (a popular form of EP), an additional 30,000 to 40,000 download it each month, and nearly half a million people actively subscribe to the twice-weekly *EFT Insights* e-letter (G. Craig, personal communication, September 17, 2009).

Nonetheless, most psychologists do not view EP as a viable treatment option (Norcross, Koocher, & Garofalo, 2006). Even though empirical evidence for EP is accumulating and has arguably already reached the threshold for what the Society of Clinical Psychology (Division 12 of the American Psychological Association) considers a "probably efficacious treatment" for specified conditions (Feinstein, 2008a), its efficacy has not yet been firmly established scientifically. The approach has, in fact, been denigrated in prestigious clinical journals as an unsubstantiated treatment about which "psychologists are not obliged to pay any attention" (McNally, 2001, p. 1173) and even as a source of "possible threats to the science of psychology and psychiatry" (Devilly, 2005, p. 437). In 1999, the American Psychological Association took the unprecedented step of censuring the approach, notifying its CE sponsors by a memo that they risked losing their sponsorship status if they offered APA CE credit for courses in the earliest established form of EP, Thought Field Therapy (Murray, 1999), and this restriction has now been generalized to all forms of EP.

In addressing the controversies surrounding EP, we will begin with reasons the approach has become such a strong area of contention within the mental health profession. The bulk of the paper, however, will focus on controversies among EP practitioners, such as a) the field's most

viable explanatory models, b) its most effective protocols, c) how the approach interfaces with other forms of clinical practice, d) conditions it can treat, e) what should be done when the method does not seem to work, and f) how the professional community should respond to the plethora of practitioners who do not have mental health credentials.

Acceptance within the Mental Health Field

Like most biological mutations, the vast majority of clinical innovations do not bring benefits that result in their ultimately being passed along to future generations. Practitioners are wise to be skeptical of enthusiastic claims and aggressively promulgated therapies. Nonetheless, just as some mutations do benefit a species, some clinical innovations move a field forward. Systemic resistance to innovation serves to keep conventional procedures neatly ordered while inhibiting progress. The medical field, for instance, has an embarrassing history that extends from ridiculing the notion that physicians should wash their hands before performing surgery to ignoring a known cure for scurvy as thousands of sailors died. To briefly characterize the situation with EP, enthusiasts for the approach believe it to be the psychotherapeutic equivalent of penicillin while its detractors believe it has no more new active ingredients than sugar water injections.

Although I was immediately impressed by the results I witnessed watching EP demonstrations and hearing about treatment outcomes, I was intellectually flummoxed by the wide range of approaches and explanations being proposed. To try to make some sense of the strange mix, I gathered a team 27 of the field's most well-known pioneers and leaders—proponents of a divergent range of EP approaches—and posed a challenge: "Can we develop a professional training program that represents a consensus regarding the methods and principles an experienced clinician new to EP should master before introducing EP into his or her clinical practice." This resulted in the book/CD-ROM training program *Energy Psychology Interactive* (Feinstein, 2004). I learned a great deal in the process. Asking the team to speculate on causes for the slow acceptance of EP, the reasons given by these key players ranged from reliance on concepts that cannot be measured, such as "subtle energies" and "thought fields," to the lack of empirical research, to uncertainty about the mechanisms of action, to the inherent paradigm clash between ancient healing systems and conventional psychological explanations for therapeutic change. A more fundamental credibility problem, however, was also frequently mentioned in those discussions. And that is *cognitive dissonance*. There is nothing in the training or background of most clinicians or researchers that prepares them to understand how tapping on the skin can help overcome severe psychological disorders, no less to account for the speed and power with which positive clinical results are being reported for challenging conditions

In fact, every therapist I have interviewed who has adopted EP reports some version of the following trajectory in coming to accept EP as a viable treatment approach: (a) disbelief upon hearing it described, (b) cognitive dissonance upon seeing it performed, (c) puzzlement mixed with relief and appreciation as the method helped resolve a tricky personal issue, (d) tentative application with others leading to surprisingly favorable outcomes, (e) frequent and confident application in clinical situations with, nonetheless, (f) a consistent sense of inner surprise in the sense of, "Wow, it worked again!" This journey from doubter to believer causes suspicion in colleagues looking on yet cements the certainty of the practitioner. Therapists who have moved

through these stages represent a broad spectrum of professional orientations and backgrounds, and they describe the approach with enthusiasm, but practitioner exuberance is not known to be reliable evidence of efficacy.

The psychotherapy field has, in fact, a long history—dating back to phrenology and Anton Mesmer's magnetic rods—of diagnostic and therapeutic approaches that were once widely touted and embraced but ultimately proved ineffective and sometimes deceptive. Even the most sincerely promulgated methods are frequently shown to have less therapeutic benefit than initially reported when their use by practitioners who did not develop them are investigated over time. Is EP another highly publicized therapy that will soon be universally recognized as being clinically hollow; is it old wine in new skin, producing positive results by repackaging established therapeutic modalities; or do its methods represent genuine and significant innovation?

Definitive answers to these questions will emerge only from further empirical investigation. Efficacy research on EP is promising (Feinstein, 2008a), but it is still in a relatively early stage. Well-controlled comparison studies between EP and treatment approaches whose efficacy have been scientifically established are yet to be conducted, so the favorable comparisons of EP in relation to CBT that can be made based on preliminary studies (discussed above) might not hold up to more rigorous scrutiny. Dismantling studies are also needed to identify the active ingredients of the various EP components and approaches.

It could, however, be another decade before such questions have been adequately addressed by rigorous empirical investigation. Clinical practice always runs ahead of research confirmation, and different practitioners have different thresholds regarding the degree of evidence that is required before a new method will interest them. Of those who have ventured into EP by learning enough of its fundamentals to experiment with it in their practices, an unknown proportion have found it useful enough to continue to apply its methods. The Association for Comprehensive Energy Psychology, a professional organization with its own code of ethics and certification program, is approaching a thousand members and numerous other EP organizations also have licensed therapists in their membership. Meanwhile, clinicians and researchers who find it untenable to entertain a) the notion that tapping on the skin can help overcome psychological problems, b) the appeal to explanations from ancient healing traditions, or c) the claims of extraordinary results in relationship to established therapies will hold to the maxim that *extraordinary claims require extraordinary proof* (after Truzzi, 1976). Until a standard of proof that few therapies have met has been established, they will continue to consider it a disservice to the public to promote EP. But as those applying EP continue to expand beyond the method's originators and early protégés, if they also continue to report that extraordinary results are typical, EP will continue to be an area of fierce contention within the mental health field for some time.

Explanatory Models

The use of the term "energy" within "energy psychology" has been scientifically challenging and a public relations disaster within the mental health professions. These difficulties do not, however, necessarily reflect conceptual shortcomings within EP. Health and

mental health paradigms have remained curiously Newtonian despite the past century's quantum revolution in physics (Lipton, 2005) where the fundamental role of energy in nature is as familiar as $E = mc^2$. In short, the notion that invisible energies and "fields of information" organize matter as well as mental processes (McTaggart, 2003) is stranger to psychotherapists than it is to physicists. Yet it may be that shifts in underlying energies and organizing fields prove to be the most parsimonious way of explaining the rapid changes reported by EP practitioners.

Meanwhile, basic "energy" concepts are finding their way into health and mental health care. From Endhoven's Nobel prize for his 1907 discovery of the heart's energy field to Berger's 1920 discovery of the brain's energy field (Church, 2009) to the widespread use of EEG (electroencephalography), EKG (electrocardiography), and MEG (magnetoencephalography) technology, and the promising outcomes of methods such as transcranial direct current stimulation with depressed patients (Nitsche, Boggio, Fregni, & Pascual-Leone, 2009), the roles of electrical impulses, electromagnetic fields, and other energies within the body that are involved in health and mental health have become undeniable. "Subtle" energies which cannot be detected or measured by standardized instrumentation—as described in acupuncture theory, other healing traditions, and a number of Western lines of investigation (see Oschman, 2000)—have not, however, been as well accepted.

In an attempt to ground the field within an empirical foundation, various EP theorists have begun to produce explanatory models that are consistent with conventional mental health paradigms, to the extent that some (e.g., Ruden, in press) have totally removed the terms "energy" and "energy psychology" from their nomenclature. It should be noted, however, that these explanations are not necessarily incompatible with an energy framework. They attempt rather to elucidate fundamental mechanisms within the context of observable empirical data without attempting to verify or falsify possible parallel processes at the level of subtle energies or organizing fields that cannot be measured by existing instrumentation. For instance, many EP protocols for treating anxiety disorders involve brief psychological exposure while stimulating acupuncture points. Specific acupuncture points, when stimulated, have been shown to send deactivating signals to the amygdala (Dhond, Kettner, & Napadow, 2007; Hui et al., 2005), and a mechanical explanation for the surprisingly rapid positive impact of EP on anxiety disorders has been formulated around these empirical observations (Feinstein, 2009). By this account, (a) evoking anxiety-producing memories or cues while (b) simultaneously sending deactivating signals to the amygdala via acupoint stimulation (c) prevents the memory or cue from triggering the anxious response.

This formulation accounts for the actions of EP in the strong outcomes being reported following treatments for anxiety disorders such as PTSD, and it does so without relying on concepts such as subtle energies or organizing fields. Preliminary evidence for the deactivating effects of specific acupoints on *conditioned fear* has been established, but a much wider range of conditions has been reported for which treatments that combine imagination and acupoint stimulation seem effective (from overcoming various problematic emotions to improving sports performance to ameliorating physical ailments). Speculation on whether additional acupoints impact other problematic emotions such as anger or jealousy, disinhibit positive emotions, or activate motivational centers is tempting and would be consistent with acupuncture theory (Kaptchuk, 2000). In an another expansive but still mechanical explanation for the actions of EP,

Feinstein and Church (2009) have shown how EP interventions may allow targeted changes in gene expression that in themselves lead to improved psychological functioning. These models lend themselves to empirical investigation.

Some clinical reports, however, seem to require explanatory frameworks that simply cannot be reduced to conventional terms. On the outer edge of these anecdotal accounts are claims of "non-local" beneficial effects of tapping on one's own acupoints with the intention of benefiting another individual (several dozen such accounts may be found by putting "surrogate tapping" into the search engine at http://emofree.com), analogous perhaps to the actions of other "outside-the-paradigm" phenomena such as remote healing or intercessory prayer (see Dossey, 2008).

How Strictly Must Energy Psychology Protocols Be Followed and Which Protocols Are Most Effective?

Even with the efficacy of acupuncture for specific conditions reasonably well-established (e.g., World Health Organization, 2003), some investigators believe that the positive outcomes are largely based on placebo effects (e.g., Ernst, 2006). In EP, the resolution of questions involving placebo, active ingredients, and efficacious procedures is further confounded by the fact that more than 30 variations of EP have been identified (Feinstein, 2004). The proponents of these approaches describe each in terms that are to some degree unique from the descriptions used for other approaches, and some focus on energies other than the meridians (in acupuncture theory, the meridians are the basic energy pathways on which the acupoints are situated, and the meridians are the first system to be affected by acupoint stimulation). The Association for Comprehensive Energy Psychology (http://energypsych.org) defines its scope as encompassing work with not only the acupoints and meridians but also the chakras (e.g., Eden, 2008) and the biofield (e.g., Rubik, 2002). The number of practitioners whose primary focus is on acupoints, however, vastly exceeds those focusing on other energy systems, and the current discussion is oriented primarily toward meridian/acupoint-based psychotherapies.

Beyond the energy system that is of primary concern, the various approaches have developed their own protocols and supplementary procedures, multiplying the variables involved in questions about whether all EP approaches are essentially equivalent or whether their auxiliary procedures play an active role (or even *the* active role) in the reported positive clinical outcomes. Nonetheless, almost all the approaches share two common elements (the use of brief psychological exposure and simultaneous stimulation of one of the body's energy systems) that are probable salient clinical ingredients in the treatment of anxiety disorders. But even here, there are inconsistencies. Clinical reports and some preliminary evidence suggest that:

1. Variations in the order, number, and selection of acupoints may not affect outcomes. Pignotti (2005) had 33 subjects tap a set of acupoints according to Thought Field Therapy (TFT) protocols that were keyed to the presenting problem and another 33 subjects tap acupoints randomly selected from those used in TFT and applied in a random sequence. Both groups showed equal pre- to post-treatment improvement, with an extraordinary 97 percent of the participants in each group reporting elimination of subjective emotional distress about the presenting problem after a single session, suggesting that the specific points and the order in

which they are tapped is less important than suggested by the TFT protocols. Joaquín Andrade, a physician trained in both TFT and medical acupuncture, supervised a series of in-house exploratory investigations of imaginal exposure/acupoint tapping with staff he had trained at 11 clinics in Uruguay and Argentina (reported in Andrade and Feinstein, 2004). Andrade found that 43 of 60 phobic patients showed improvement after a single session using one tapping protocol while a statistically equivalent 46 of another group of 60 phobic patients showed improvement using the same protocol but with the points tapped in a different order. In a related set of pilot studies, Andrade found that varying the number of points that were stimulated, the specific points, and the inclusion of standard auxiliary interventions generally did not result in significant differences. A conclusion of the treatment teams involved in these exploratory studies was that "for many disorders, such as specific phobias, wide variations can be employed in terms of the points that are stimulated and the specifics of the protocol" but for more complex or intractable disorders, adherence to the protocols may support a more "favorable clinical response" (p. 203).

2. Various methods of stimulating acupoints may be equally effective. In addition to tapping on acupoints or inserting traditional acupuncture needles into them, some practitioners massage (Eden, 2008) or simply make light contact with (Diepold, Britt, & Bender, 2004; Fleming, 2007) the acupoints. While there is so far little research comparing these methods to one another, another pilot study from the South America group did compare tapping with the use of traditional acupuncture needles. Forty panic patients received tapping treatments on pre-selected acupuncture points and 38 panic patients had acupuncture needles inserted into the same points. Positive responses were found for 78.5 percent of the participants in the tapping group and 50 percent in the needle group, suggesting that tapping was at least as effective as and possibly more effective than the use of traditional acupoint needles in the treatment of panic disorder (Andrade & Feinstein, 2004). A recent double blind study comparing penetration by acupuncture needling with non-penetrating pressure also found the clinical improvements for both types of intervention to be equivalent (Takakura & Yajima, 2009).

3. Are traditional acupoints more effective than "sham" points? Several studies suggest that stimulating traditional acupuncture points is more effective than stimulating sham points (e.g., Barker et al, 2006; Kober et al., 2002; Lang et al. 2006; Wang et al., 2007), and the points used in acupuncture have indeed been shown to have greater electromagnetic conductivity than other areas of the skin (Ahn, Wu, Badger, Hammerschlag, & Langevin, 2005). In a large-scale German study comparing medication, acupuncture sessions using traditional points, and acupuncture sessions using sham points, 835 migraine patients were randomly assigned to one of the three treatment conditions (Diener, 2006). The medication and traditional acupuncture treatments decisively reduced the occurrence of migraines (both at $p < .0001$), with each having about equal success (reduction by 2.3 symptom-days vs. a reduction of 2.1 days, respectively, over a six-month period). The sham-point acupuncture led to a reduction by 1.6 symptom-days. While the difference between the traditional acupuncture points and the sham points did not quite reach statistical significance ($p < .09$), the fact that the traditional points did result in 31 percent more symptom-free days would equivocally support speculation that the traditional points may have therapeutic properties the sham points do not.

Waite and Holder (2003), using a modified EFT protocol for self-reported fear of heights, found that it did not matter whether the standard EFT points, random points on the arm, or points

on the middle and index fingers that are stimulated while tapping on a doll were used. All three tapping conditions resulted in significant reductions in the self-reported fear of heights ($p < .003$, .001, and .001, respectively). This fear was not reduced in a no-tapping placebo group ($p = .255$), leading the investigators to conclude that acupoint tapping was not the active ingredient in the observed improvements. In a review of these findings, however, Baker, Carrington, and Putilin (2009) pointed out that the Waite and Holder study actually put EFT to an extremely "stringent test by posing the question: does very brief and atypical participant exposure to EFT (as compared to the much longer sessions routinely used in clinical practice) show any effects?" (p. 39). Based on Waite and Holder's data, they commented that a single round of a few minutes of EFT produced "significant decreases in fear . . . We know of no laboratory controlled study in the literature using a traditional psychotherapeutic modality that has produced such a rapid statistically significant effect" (p. 42). They point out a number of reasons the investigators may have missed these implications of their findings. For instance, the investigators did not take into account the possibility that acupoints on the arm and the fingers used for tapping the doll were being stimulated in the "no acupoint" conditions (for example, tapping on the forefinger stimulates "Large Intestine 1," an acupuncture point that is sometimes used in the treatment of "mental restlessness," Ross, 1995, p. 306; another important acupuncture point, Pericardium 9, is located at the tip of the middle finger). The findings of the Waite and Holder study and the migraine study suggest, nonetheless, that tapping any points on the skin may have some therapeutic value.

Some light on the question is shed by an experiment where researchers used positron emission tomography (PET) to see what was occurring in the brains of 14 people having acupuncture treatment for painful osteoarthritis (Pariente, White, Frackowiak, & Lewith, 2005). All 14 underwent each of three treatment conditions in a random order. In one condition, blunt needles touched the patients' skin, but the patients were aware that the needle would not pierce the skin and were told that it would not have any therapeutic value. In a second condition, specially developed "trick" needles were used. These gave the impression that the skin was being penetrated even though the needles never actually pierced the skin. Rather, like a "stage dagger," the tip of the needle moved up into the body of the needle. The third condition was conventional acupuncture. The PET scans revealed marked differences in brain activity for each of the interventions. When the patients were touched with the blunt needles, only the brain areas associated with the sensation of touch were activated. With the trick needle, an area of the brain associated with the production of natural opiates was also activated. Natural opiates act in a non-specific way to relieve pain, so their production following the trick needle treatment may have constituted the neurological dimension of a placebo effect. With the real acupuncture, the part of the brain which produces natural opiates was also activated, but another region, known as the insular, and thought to be involved in pain modulation, was activated as well. So while the belief that acupuncture was being administered did produce non-specific therapeutic effects, the real acupuncture produced additional, more specific effects.

Even though preliminary evidence suggests that acupoint stimulation reduces amygdala hyperarousal (Dhond et al., 2007; Hui et al., 2005), it is also possible that tapping on acupoints simply sends the amygdala physiological information that is not congruent with the presence of threat, resulting in rapid inhibition of the acute stress response. As Church succinctly explains to

his students, “In the language of evolutionary biology, you wouldn’t be tapping if you were being chased by a tiger” (cited in Feinstein & Church, 2009).

Nearly all published EP studies investigate efficacy rather than mechanisms. While research exploring procedural issues is needed before definitive statements can be made, preliminary observations and related research suggest that variations in the order of acupoints stimulated, number stimulated, specific points stimulated, and the methods of stimulating them have less importance than suggested in the original formulations of EP protocols. Preliminary evidence does, however, suggest at least some greater clinical effectiveness for traditional points compared with sham points.

The Interface of Energy Psychology and Other Clinical Approaches

Although EP can be conceived of as an independent, self-contained modality, most psychotherapists who learn the approach integrate it into their existing personal clinical framework. What acupoint stimulation seems to add to conventional treatment is *a technology that allows neurological patterns such as maladaptive conditioning to be redressed with unusual speed and efficiency.* While the acupoint protocols are largely mechanical, easy to learn, and routinely taught to clients for back-home application, to children for managing anger or fear, and to athletes for boosting their performance, psychotherapists are still called upon to bring a sophisticated understanding of clinical issues when applying the approach with complex emotional problems. EP for serious psychopathology is, in fact, more usefully understood as a set of affect-management tools for the experienced clinician than as an autonomous therapeutic system (Feinstein, 2004). The practitioner’s clinical skills in terms of building rapport, attunement to the client’s inner world, and grasp of the relevant features of the clinical situation seem vital to the successful treatment of complex disorders.

In addressing recalcitrant conditions such as borderline personality disorder, substance abuse, or endogenous depression, established “best practices” also still apply. With borderline personality disorder, for instance, close attention to maintaining the therapeutic bond, limit-setting, anticipating impulsive behaviors, and a myriad of other considerations (e.g., Linehan, 1993) are as important when EP techniques are being used as when they are not. EP interventions can, however, be strong resources for a spectrum of clinical challenges that typically arise—from reducing hyperarousal during engagement with traumatic memories to changing conditioned responses to providing patients with back-home techniques for better managing problematic impulses.

Conditions for Which EP is Most Likely to Be Effective

The most systematic data currently available on the conditions for which EP is effective are based on practitioner surveys. Schulz (2009, this issue) found that 12 licensed psychologists who used EP in treating adult survivors of childhood sexual abuse reported believing that EP is the most effective approach available for the anxiety, panic attacks, and phobias found in adult survivors. Seven of them typically combine EP with talk therapy, CBT, and/or EMDR in working with this population while EP was the primary modality used by the other five. All 12 also reported observing improved mood, self-esteem, and interpersonal relationships when using

EP with adult survivors. Ten of them attributed decreases in the dissociative symptoms of their abused clients to EP, with better self-care and less self-harming behaviors also being reported.

The impressions about EP outcomes with anxiety, panic attacks, phobias, and improved mood are consistent with two other surveys of EP practitioners, one originating in North America, the other in South America (described in Feinstein, 2008a). In the North America survey, eighteen clinicians who were identified as leaders in EP within the United States and Canada (based on criteria that included publications on the topic, teaching positions in established training programs, and visibility at national and international conferences), and who are also trained in conventional therapies, offered their impressions of the diagnostic categories where EP was more effective, about as effective, or less effective than the other modalities available to them. The survey used a subset of the diagnostic categories specified in an earlier report of therapist impressions at 11 clinics in Argentina and Uruguay that had adopted EP (Andrade & Feinstein, 2004), and it produced parallel findings.

The therapists in both the North and South American groups all reported that they found EP to be more effective than the other approaches available to them for treating most anxiety disorders, including the hyperarousal found in PTSD, as well as for many of the most common emotional difficulties of everyday life, from excessive anger to inappropriate feelings of guilt, shame, grief, jealousy, rejection, and isolation. Conditions for which combining EP with more conventional treatments was believed to produce more rapid outcomes than the conventional treatment alone included mild to moderate reactive depression, generalized anxiety disorder, obsessive-compulsive disorders, learning skills disorders, borderline personality disorder, eating disorders, and substance abuse. Most of the respondents in both groups reported that they believed EP's effectiveness is limited in overcoming major endogenous depression, dissociative identity disorder (DID), bipolar disorders, many personality disorders, and psychotic disorders. When I was presenting these practitioner impressions at an EP conference in 2006, however, a woman in the audience was incensed by this last statement. She reported that the clinic where she works, which is known for treating DID, reduced the average time for successful treatment from 3 to 5 years to under 2 years after introducing EP. One survey respondent did describe, in a comment, some success in resolving the early trauma that is implicated in DID, and another described the reduction of auditory and visual hallucinations with psychotic disorders. Several also mentioned that while they did not see EP as an independent treatment for psychotic disorders, it had helped individuals with debilitating psychiatric conditions make better adjustments to their diagnosis and their life situation, in part by reducing the stress associated with the primary condition and in part by enhancing coping skills.

The only harm reported was that in the hands of inexperienced or lay therapists, people have sometimes been retraumatized, not by the technique itself, but by revisiting unresolved trauma without adequate preparation or support. The relative safety of the method has been corroborated by other investigators (e.g., Mollon, 2007). Ethical issues, however, can converge with clinical issues in ways that may be highly challenging. In a discussion of challenges the field could anticipate, I predicted that ethical concerns will emerge both in terms of the practitioners competence and scope of practice issues as well as blatantly manipulative applications, such as schools using energy interventions to promote obedience to authority or the military using them to make soldiers less conscience-bound in their ability to hurt others (Feinstein, 2004, p. 253). In a highly charged incident that touches on the potential power of EP

to cause people to violate their own moral principles, psychologist Patricia Carrington was doing a crisis intervention session with a very unstable man whose rage had previously led to incarcerations while he was in the military. One of the concerns he presented was his hatred toward a co-worker and impulses of damaging others that he had been able to control but was concerned he would not be successful in continuing to control. After tapping, using phrases that included "I deeply and completely accept myself," he had an epiphany where in his mind it was acceptable to take out a revolver he kept in his office desk drawer and kill his colleague. He calmly reported, "It just came clear to me while I was doing the tapping. That's what I am going to do. I feel okay about it now. I accept myself." This so scared Dr. Carrington, one of the luminaries in the emergence of EP, that she skillfully turned the conversation to psychiatric medication and had the man engaged within hours with a psychiatrist who had been fully prepped on the situation (Carrington, 2000).

Another finding of interest, mentioned in a few informal interviews I conducted as follow-up to the survey, was that practitioners trained first in EMDR and then in EP reported that EP both provides greater flexibility in the range of issues that can be addressed and that its methods can be more readily modulated by the practitioner to prevent retraumatization, an issue that has been of concern with EMDR treatments (Hartung & Galvin, 2003). A question about using tapping methods with individuals who have convulsive disorders was mentioned by one respondent, although no instances of harm were described. While these reports originate from therapists who are professionally identified with and favorable toward EP and are only initial impressions, they do identify conditions and populations for which applications of EP might be more systematically investigated.

When Basic EP Protocols Don't Work

When acupoint stimulation combined with mentally focusing on a goal or target problem fails to produce the intended psychological effects, a variety of corrective measures are available to the practitioner. Which of these to employ is, however, a matter of controversy. There seems to be general agreement that ambivalence or internal objections about overcoming the presenting problem (called a "psychological reversal") requires attention in order for the acupoint stimulation to be fully effective (Callahan & Callahan, 1996; Craig, 2008), and specific protocols for overcoming psychological reversals have been formulated (Gallo, 2000). Choice of the scene or issue on which to focus during the acupoint stimulation also seems critical, with unresolved "aspects" (Feinstein, Craig, & Eden, 2005) sometimes requiring attention before further progress can be made. The degree to which it is necessary to address unresolved emotions from the person's history in order to overcome current problems is another matter where clinical sophistication and varying opinions come into play. In addition to these psychological dimensions of treatment are questions about the physical procedures. Some practitioners have elaborate protocols for determining the most effective acupoints for a particular issue with a particular individual (e.g., Gallo, 2000). Others hold that a uniform and unvarying set of points is adequate for virtually any clinical situation and that the challenge for successful treatment is to identify core issues and separate them into specific feelings, images, and events that can be addressed via acupoint stimulation (e.g., Craig, 2008). Most practitioners recognize that if a person is unable to focus or concentrate adequately, the effectiveness of other procedures will be compromised, but some place greater emphasis on the client's neurological stability and on balancing the body's various energy systems (e.g., Eldringhoff, 2009, this issue). Practitioners

whose background is in the broader field from which EP is derived, energy medicine (e.g., Eden, 2008), are particularly attuned to correcting for ways problems in specific energy systems may be interfering with attaining desired psychological outcomes.

Gruder (2001) has offered five guidelines or "keys" for successful EP treatment. These guidelines, briefly summarized here, are also valuable for analyzing what may need attention if treatment stalls:

1. Attune to the "Top Priority Issue": Identify and work with the issue that has the greatest leverage. While clinical practice often involves finding one's way to the most salient issues through observation, experiment, and mutual problem-solving with the client, the guiding principle is to stay alert for the issue that is likely to yield the strongest effect from the simplest intervention.

2. Establish a Readiness to Benefit from the Treatment: Four levels of "readiness" include a) "electromagnetic readiness" (basic stability and responsiveness in terms of the body's energy systems), b) neurological readiness, c) internal permission (this includes having overcome any "psychological reversals" or other unconscious interference with therapeutic intent), and d) interpersonal readiness in terms of rapport, counter-transference, and the practitioner's ability to adequately engage the client's issues.

3. Select the Best Treatment Method: Once the top priority issue has been identified and a readiness to benefit from treatment established, the treatment method may involve mental activation of an issue while stimulating acupoints, different EP protocols, or methods outside of an EP framework. The guiding question for the clinician is: "What is the *best* treatment (a) at this time (b) for this person (c) for this issue (d) for this level/aspect of the issue?"

4. Confirm Full Completion of the Treatment: The treatment will be more durable if hidden aspects and layers of the issue have been identified and addressed, if the gains are tested in the person's imagination against a possible scenario that would challenge the results to see if maladaptive emotions reemerge, and finally tested in a real world setting with EP tools at the person's disposal to provide in-the-moment support as well as provisions for further refinement of the treatment if necessary.

5. Upgrade the Undisturbed State with Peak Functioning: The resolution of a problem can actually create a sort of psychological vacuum. But it also creates an opportunity to envision peak functioning in the area the problem was limiting the person. Guidance can be given for creating a vivid, multi-sensory image of how the person would ideally *like to be* when in the kind of situation that once evoked the problem.

Practitioners Who Do Not Have Training in the Mental Health Field

A variety of personal development approaches that are independent of formal psychotherapy use EP protocols. Business executives are "coached" on how to overcome obstacles to success. Athletes are shown how to optimize their confidence and performance on the field. Physicians and other health care practitioners, recognizing the role of psychological

factors in illness, are incorporating EP techniques to address their patients' anxieties, possible emotional obstacles to healing, and to enhance immune function. Even parents with minimal training in EP may teach their children to use EP to calm fears after a nightmare or anxieties about going to school. Should practitioners providing such services be required to have mental health training, degrees, or licensure? Here the EP field is deeply divided.

With nearly half a million people actively subscribing to the *EFT Insights* e-letter, the vast majority of them presumably being lay practitioners, and more than thirty other EP modalities or organizations in existence, EP is a popular movement that prizes self-empowerment and views EP as a potent means for promoting it. On the other hand, seasoned therapists who have incorporated EP, and the clinical community in general, are concerned that lay practitioners may find themselves working with conditions that are far beyond their competence, leading to no gain, possible harm, and preventing or delaying people from receiving needed help. Some of the EP practitioners who completed the surveys summarized earlier reported being consulted by people with psychiatric disorders that had been exasperated by practitioners without adequate sophistication about mental health issues. A guideline within the EP community has been to distinguish between a) "personal coaching," where the diagnosis or treatment of psychiatric disorders is not attempted, and b) psychotherapy, where the treatment of psychiatric disorders *is* the service being offered. Only licensed mental health practitioners are legally or ethically sanctioned to provide the latter.

People who receive EP services outside a mental health context do not, however, necessarily fit within or stay within only one of these two categories (Feinstein & Eden, in press). A *DSM* psychiatric disorder (American Psychiatric Association, 1994) may reveal itself in a person seeking help for an apparently unrelated goal, or a *DSM* disorder such as anxiety or depression may need to be overcome before the person's goal can be fully attained. A business man, seeking EP help to become a more effective leader of his employees, may be hindered by anxiety for which he is unwilling to see a mental health professional. A life coach may have been focusing on obstacles to intimacy when, between sessions, the client is robbed at gunpoint and comes in with symptoms of traumatic stress. An athlete's inability to reach her full potential may trace to the aftermath of physical abuse during childhood. Can EP practitioners without a mental health background but with tools for which at least some *DSM* disorders respond readily and with little complication use those tools when situations arise where addressing the *DSM* disorder seems appropriate to the practitioner?

Most state laws and the bulk of the mental health community discourage or prohibit practitioners without mental health credentials from venturing into such territory. A perusal of the thousands of cases presented on the Emotional Freedom Techniques website (http://emofree.com), however, reveals a popular movement where such distinctions are not necessarily observed and low-cost, non-stigmatizing help has been offered with strong favorable outcomes reported. The dilemmas for the mental health field are stark. Attempting to curb all of these activities with strict prohibitions when there are many gray areas, besides being an impossible objective, would appear self-serving and not in the interest of promoting the public welfare. The early proponents of EP were licensed therapists, and they did in fact attempt to turn their innovations into a proprietary, trademarked modality. Gary Craig, founder of EFT, synthesized the essential principles and procedures into a protocol that virtually anyone could

apply and, in a spirit parallel to that of open source software, gave it away freely and encouraged others to build upon it. More than a million people have responded.

Concerns about client safety are, nonetheless, highly pertinent, and cautions about working with serious *DSM* disorders are recommended even by Craig (2008), one of the most enthusiastic proponents for the popular use of the method. By distancing itself from EP, however, the professional community has missed an opportunity to participate in establishing foundational guidelines for the popular application of the method. Yet it still has much to offer for teaching lay practitioners basic counseling and crisis intervention skills, the fundamentals of human psychology, and established principles for recognizing mental health conditions where referrals are appropriate.

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