Last Revised: May 18, 2006

www.EnergyTraumaTreatment.com.

Updated and expanded from an article that appeared in the March-May 2006 issue of *Shift: At the Frontiers of Consciousness*, published by the Institute of Noetic Sciences (www.noetic.org).

ENERGY PSYCHOLOGY IN DISASTER RELIEF

David Feinstein, Ph.D.

Energy psychology is an approach to psychotherapy and emotional self-management that uses the stimulation of "energy points" on the skin for the purpose of changing specific emotional response patterns. It is highly controversial within the psychological community. On the one hand, the rapid positive results being reported with energy psychology make no sense in terms of the stock concepts of psychotherapy, such as insight, problem-solving, contingency management (incentive-based change), interpersonal support, or the curative powers of the therapeutic relationship. On the other hand, when a person with a lifelong fear of heights walks toward the edge of a 20th-story balcony, starts to sweat, shake, and appears compelled to back away, and then, after 30 minutes of a largely mechanical treatment, that same person walks calmly to the railing and enthusiastically leans out to admire the view, it is striking. When you see a comparable scenario 10 times out of 12, it is persuasive. While energy psychology is backed by more than thirty thousand documented cases and a credible and growing professional organization, its acceptance, as might be expected with any radically new approach, has been slow within the broader psychotherapeutic community.

Energy Psychology in the Field

For a therapeutic innovation to prevail, it must pass many tests. These tests are even more stringent if the technique is rooted in a paradigm adopted from a foreign culture and uses unfamiliar and odd-looking techniques. Both characteristics apply to energy psychology (EP), which is rooted in Traditional Chinese Medicine and uses methods such as having the patient tap on acupuncture points while humming and counting. Regardless, however, of lineage or technique, an acid test for therapies such as EP, which claim to be particularly effective with trauma relief, is their usefulness in the wake of profound disasters. Even while systematic research studies on EP are only beginning to appear, a legacy of the method's effectiveness in disaster areas has been accumulating.

Carl Johnson, Ph.D., a clinical psychologist retired from a career as a PTSD (post-traumatic stress disorder) specialist with the Veteran's Administration has, over the past six years, frequently traveled to the sites of some of the world's most terrible atrocities and disasters to provide psychological support based in EP methods. About a year after NATO put an end to the ethnic cleansing in Kosovo, Dr. Johnson found himself in a trailer in a small village where the atrocities had been particularly severe. A local physician who had offered to refer people in his village had posted a sign that treatments for trauma were being offered. On the afternoon of a

very hot summer day, a line of people had formed outside of the trailer. The referring physician told Johnson, with some concern, that everyone in the village was afraid of one of the men who was waiting outside for treatment.

Indeed, when Johnson looked outside, he saw that the others had positioned themselves as far away from this man as possible. Johnson decided to start with him and invited him into the trailer. Johnson, who 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 had the man identify the trauma for which he wanted help. Everyone in the village was haunted by traumas of unspeakable proportion: torture, rape, witnessing the massacre of loved ones. The man brought the trauma to mind, and though he never put his memory into words, his treatment began. Johnson tapped on specific acupuncture points that he identified using a simple physical test. He then instructed the man, through the interpreter, to do a number of eye movements and other simple physical activities. Then more tapping. Within fifteen minutes, according to Johnson, the man's demeanor had changed completely. His face had relaxed. 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 in wonder.

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 gleeful in his thanks. He knew that 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, 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 tortured souls were relieved of their suffering, they became palpably loving. Additional case studies from numerous disaster sites can be found in the following report.

The Kosovo Data and Beyond

The majority of the first 105 people treated in Kosovo by Johnson and his colleagues were followed for 18 months after their treatments. The results are astounding. These individuals were suffering from the post-traumatic emotional effects of 249 discrete, horrific self-identified incidents, from torture and rape to witnessing the massacre of loved ones. For 247 of those 249 memories, the treatments (using Thought Field Therapy, an early formulation of energy psychology developed by Roger Callahan, Ph.D., in the early 1980s) successfully reduced the reported degree of emotional distress not just to a manageable level but to a "no distress" level ("0" on a 0-to-10 "Subjective Units of Distress" scale). The memories, of course remained, and though they were no less horrific, they were no longer emotionally disabling.

Johnson made nine trips to Kosovo between February 2000 and June 2002. His later visits were as much to train local health care providers in Thought Field Therapy as to treat additional patients. He also received follow-up information on approximately three-fourths of the initial 105 people treated, primarily from two physicians who participated as translators in the initial treatments and who continued to care for the individuals who received the treatments. Interestingly, once a memory had been cleared of its emotional charge, it remained clear. The initial treatment had proven a potent and durable healing in all cases. The physicians eventually did ask Johnson to see two of the patients a second time, and their problems – similar though less intense than the original memories – were treated. Reports of these treatments came to the attention of the chief medical officer of Kosovo (the equivalent of the U.S. Surgeon General), Dr. Skkelzen Syla, who investigated them and subsequently stated in a letter of appreciation:

> Many well-funded relief organizations have treated the post traumatic 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].

Johnson kept a very simple but ultimately provocative set of statistics during his visits to Kosovo and other areas of ethnic cleansing, warfare, and natural disasters:

- Number of people treated
- Number of people treated successfully (hyperarousal to traumatic memories neutralized)
- Number of traumatic incidents identified
- Number of incidents where complete relief was reported

Here is his tally to date:

Country	# of Clients	# Treated Successfully	# of Traumas Identified	# Completely Resolved
Kosovo	189	187	547	545
South Africa	97	97	315	315
Rwanda	22	22	73	73
Congo	29	28	78	77
TOTALS	337	334	1016	1013

Johnson, who holds diplomate status with the American Board of Professional Psychology, acknowledges that these figures raise even his own skepticism. The findings “feel embarrassingly too-good-to-be-true,” he says. While affirming that they do indeed reflect his experiences, that he “recorded them exactly according to what happened,” he wonders if the results could somehow have been inflated through translation of the language and the cultural concepts. In any case, he notes, “well-controlled research is essential before results like these can be accepted.” He also emphasizes that healing a trauma with energy therapies, as reflected in the above numbers, is not the end of a person’s healing journey. “Often it is a new beginning,” he observes, providing people an opportunity to rebuild their lives without the oppressive emotional weight of their traumatization. To this end, I noticed from our interviews that Johnson meticulously integrates the energy work into the context of the local culture’s values, social structure, family relationships, and healing traditions to support continued healing and follow-up.

While my own skepticism was also strongly triggered upon first hearing these numbers—therapy simply isn't known to produce near-100% results with any group, no less with people who have been severely traumatized—I think it is important to present Johnson's data. These treatment results were corroborated by Kosovo's chief medical officer (a highly regarded psychiatrist) and by the therapists I have spoken with who worked with Johnson in Kosovo and in Africa, and they are consistent with what others are also describing. Clinicians from a wide range of backgrounds are reporting that energy psychology treatments can rapidly and permanently clear the emotional overwhelm associated with traumatic memories.

Members of the Trauma Relief Team of the Association for Thought Field Therapy Foundation (see Organizations) have, for instance, utilized TFT while providing disaster response services in more than a dozen countries, with strong results being reported. The Humanitarian Committee of the Association for Comprehensive Energy Psychology (ACEP) reports corresponding observations based upon its work with some 300 tsunami victims. While systematic follow-up has not yet been conducted, the ACEP group describes strong, rapid responses to the psychological aftermath of the disaster, including alleviating anxiety, depression, and anger, as well as the successful resolution of earlier traumatic memories activated by the tsunami experience. One of their most interesting findings has been that, since it is more acceptable for individuals in these cultures to complain of physical suffering than emotional pain, many of the treatments focused on physical pain and consistently brought about substantial relief, based on both the survivors’ self-reports and a reduction in observable physical difficulties.

In short, while Johnson’s figures certainly aren’t science, neither should they too readily be dismissed. Disaster treatment can prevent the emotional scarring that results in impaired relationships, productivity, and health, along with painful psychological sequela such as nightmares, flashbacks, insomnia, depression, and panic disorders. In a world of terrorism, ethnic violence, wars, and natural disasters, any method that appears to be rapid, effective, and relatively easy to teach deserves serious attention.

High Impact, Slow Acceptance

Given all of this, you might think that most mental health teams involved in disaster relief would be utilizing or at least considering the use of energy psychology interventions. The professional psychotherapy community, however, has been slow to accept the new methods. The 150,000-member American Psychological Association (APA), for instance, has taken the unprecedented step of singling out energy psychology as an area whose study cannot lead to APA-approved continuing education credit. Growing numbers within its ranks, however, are becoming familiar with the power of the energy therapies, including psychologists on both the TFT Trauma Relief and the ACEP Humanitarian Teams, who have collectively seen the method give hope and healing to hundreds of the most traumatized people on the planet. But the APA has held to a 1999 directive to its continuing education providers that they risk losing their sponsorship status if they offer psychologists continuing education credit for courses in Thought Field Therapy, and this restriction has been applied to any form of energy therapy, effectively preventing untold numbers of psychologists from exploring the new methods.

The reluctance is nonetheless understandable. The methods look strange, conventional explanations do not account for the reported results, and the outcomes being reported do indeed seem extraordinary. Most seasoned therapists, even when directly witnessing the power of energy psychology treatments, are at first not sure what to make of them. The APA has been similarly equivocal. At the same time it is preventing psychologists from receiving CE credit for acquainting themselves with the new field, a review in *PsychCritiques* (APA's prestigious online book review journal) of a professional home-study program in energy psychology states: "Energy psychology is a new discipline that has been receiving attention due to its speed and effectiveness with difficult cases," and goes on to laud the work as "a valuable expansion of the traditional biopsychosocial model of psychology to include the dimension of energy."

While the psychotherapy community continues to debate the efficacy of energy interventions and even to block their proliferation until more scientific evidence has been produced, relief workers are developing guidelines for their application in global disasters. For instance, the Green Cross, a humanitarian relief organization analogous to the Red Cross, but with greater focus on alleviating the psychological consequences of trauma (see Organizations), has been working closely with the TFT Trauma Relief Team and the ACEP Humanitarian Committee to expand the number of available relief workers trained in energy psychology methods. Energy psychology is increasingly being used by counselors that Green Cross deploys to disaster areas. Psychologist Charles Figley, Ph.D., founder of the Green Cross in 1995 and a leading figure in trauma treatment, notes that "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."

Energy Psychology, Debriefing, and Cognitive Behavior Therapy

The mental health approach that has most frequently been utilized following a disaster is "Critical Incident Stress Debriefing," where emergency workers, witnesses, and bystanders who suddenly become helpers (but not "direct victims" or their families) discuss the incident in a

group format, led by a mental health professional, often teamed with a leader or associate of those who have been traumatized. What could make more intuitive sense than debriefing, where one shares, within a supportive professional context, one's experiences, thoughts, and emotional reactions with colleagues and friends who were involved in the same trauma?

To the surprise of many in the professional community, however, in-depth research has revealed that this popular mental health intervention in disaster situations can make things worse for some people and does not have a preventive effect for those who are most likely to later exhibit symptoms of post-traumatic stress disorder (PTSD). Considerable speculation on the reasons for this can be found in the trauma treatment literature. A debriefing group may, for instance, coerce 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 co-workers who were also part of the group. Debriefing may undermine the individual's natural coping strategies by inducing the person to process the trauma prematurely. Some people might, for example, be better served by a period of denial so they can rest and recover emotionally before attempting to process the trauma. Debriefing, which is often conducted on a single-session basis shortly following the traumatic event, may also open earlier traumas that are still unresolved but provide no means for reconsolidating them (a superb analysis of these issues and their implications for disaster relief can be found in "Early Intervention for Trauma," in the Summer 2002 issue of *Clinical Psychology*, pp. 112-134).

The paper cited above contrasts cognitive behavior therapy (CBT), debriefing, and other psychological interventions following traumatic events. Several studies, for instance, have shown that four to six sessions of CBT in the wake of a traumatic event is significantly more effective than no treatment or only supportive counseling in preventing the symptoms of PTSD. CBT also appears markedly more effective than a single debriefing session in preventing PTSD, and it does not appear to have the counter-therapeutic effects reported in some debriefing session participants. While both CBT and debriefing include educational components that teach the person about common reactions to trauma and coping skills for managing them, CBT also utilizes daily back-home "exposure therapy," where victims vividly relive the traumatic event in their memories and also put themselves into real-life situations they have been avoiding since the trauma. Multiple exposure to evocative memories and situations, often followed by structured practices for inducing relaxation, have the effect of "extinguishing" the strong emotional response ("hyperarousal") to the traumatic memory or the feared situation. A debriefing session, on the other hand, may simply increase arousal and distress without facilitating its resolution.

Hyperarousal to memories of a trauma, or to new situations that trigger unresolved trauma, is the stumbling block to healing that people often cannot overcome using their own devices or even conventional talk therapy (see Bessel van der Kolk's classic article, "The Body Keeps the Score," *Harvard Review of Psychiatry*, Jan-Feb 1994, 253-65). Trauma is known to adversely change limbic system structures (involved in various emotions such as aggression, fear, pleasure, and also in the formation of memory) that are not easily corrected through talk or self-reflection. It is in its ability to rapidly counter maladaptive hyperarousal in the limbic system that energy psychology may have its greatest advantage over CBT, debriefing, and other orthodox trauma interventions. Like CBT, EP identifies dysfunctional behaviors, emotions, and cognitions and targets them for change. But rather than requiring extensive exposure therapy and

relaxation training to quell the excessive emotional reaction, a traumatic event or feared situation is mentally activated at the same time that "energy points" on the skin are stimulated. This sends signals to the brain (well documented by MRI studies) that are not compatible with hyperarousal ("reciprocal inhibition"), often permanently changing the response to the memory or situation. A plausible hypothesis of the brain mechanisms that may be involved has been formulated by neurologist Ron Ruden (see www.energypsych.org/article-ruden.php).

Another advantage of energy psychology over standard trauma treatments has to do with its ability to shift irrational beliefs. A strength of CBT over debriefing is that it uses a powerful, if laborious method known as "cognitive restructuring" to challenge the maladaptive beliefs that often follow a traumatic event, such as "I deserved this" or "all men are dangerous." Energy psychology similarly examines dysfunctional self-statements and beliefs, but again its methods purportedly shift the neurological underpinnings of maladaptive beliefs more directly and rapidly than those of CBT.

Empirical investigation of energy treatment outcomes, while still in an early stage, is underway. An article available at www.EnergyPsychologyResearch.com summarizes the evidence that is available from anecdotal reports, systematic observation, and controlled experimentation. One example from this article is a large-scale study conducted in South America which compared energy psychology and Cognitive Behavior Therapy in the treatment of anxiety. While not meeting all the criteria of controlled experimentation, it did utilize a randomized design and blinded raters. Even taken simply as systematic observation, both the number of subjects involved in the study (approximately 2,500 in each treatment group) and the size of the differences in the outcomes of the two procedures (complete remission of symptoms was 76% for the energy psychology group and 51% for the CBT group) were substantial. The energy-based treatments were also more rapid (1 to 7 sessions vs. 9 to 20 sessions). However, rather than interpreting such findings in terms of EP *or* CBT, it should be emphasized that, for a growing number of clinicians, the combination of the two is proving the most powerful.

Applying Energy Psychology in Disaster Situations

Two salient questions raised by the disappointing outcomes following the widespread use of debriefing are 1) is a single-session intervention (individual or group) contraindicated in working with trauma victims, and 2) should, in fact, *any* psychological intervention be utilized soon after a trauma? Sophia Cayer, a life coach and seasoned practitioner of EFT ("Emotional Freedom Techniques," another widely used energy psychology approach), addressed the first of these questions shortly after having returned from working with hurricane victims and evacuees in Alabama following Hurricane Katrina (see cases): "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." One of the strengths of EFT is indeed the ease with which it can be learned and self-applied. Several hundred personal accounts of its successful self-application and peer-application with a wide range of psychological issues can be found at www.emofree.com.

Another single-session format where energy techniques for self-soothing can efficiently be taught is in group settings. Participants are able to experience immediate relief without having to reveal to other group members the nature of their difficulties. 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 audience members had previously identified is subsequently reported by a large proportion of the group. Called "Borrowing Benefits," the mechanisms for such outcomes are still unknown, yet many practitioners are reporting striking results. Rosanna Ellis, an EFT practitioner who used this method to successfully help all 30 people in a church in Selma, Alabama, lower their self-assessed distress levels (see case report) a month after Hurricane Katrina, notes that after a natural disaster such as a hurricane, "seeing other people quickly calm themselves gives hope."

Regarding how soon after a disaster psychological interventions should be introduced, opinions vary, but the critical distinction is that different kinds of interventions are appropriate at different points. Paul Oas, Ph.D., a member of the TFT Trauma Relief Team who has provided post-disaster energy therapy services in New Orleans, Kosovo, Rwanda, and the Congo, emphasizes that "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." For instance, Barbara Smith, a trauma specialist in New Zealand who works for a government-funded agency, often takes the official report of a person who has been recently traumatized. She needs the people she interviews to recall and recount their traumatic experiences in detail to complete the necessary paperwork. Since many of them are still in deep shock from the recent incident, and they may re-experience the horror and overwhelm of the traumatic event in talking about it, it may take up to four sessions to complete a single report. And even then, the reports might not always be clear or coherent. By simply introducing tapping and having her clients continuously tap specific acupuncture points 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."

The Green Cross outlines four "waves" for providing mental health trauma services after a disaster. In the first wave (1 to 10 days following the disaster), its services are geared toward crisis stabilization and identifying local resources for continuity of care. In the second wave (days 5 to 15), the interventions focus on stress management, social support, and further coordination with local resources. The third wave (days 10 to 20) adds to the above the assessment and referral of those with acute and long-term mental health needs, along with the development of family resources. The fourth wave (days 15 to 40) adds grief and loss counseling to the above. Energy psychology, it must be emphasized, does not replace any of these interventions. Rather, it complements and strengthens them, apparently providing a direct means for immediately impacting the neurochemistry that governs targeted outcomes such as emotional stabilization, stress reduction, or grief management. An important distinction, however, is that it is often not until several months or longer after the trauma that *healing*, as contrasted with *psychological first aid*, is possible.

The core activities for administering "psychological first aid" in the days and weeks following a trauma (according to the *Field Operations Guide* produced jointly by the National Center for PTSD and the Terrorism Disaster Branch of the National Child Traumatic Stress Network) include practical actions—such as establishing safety, comfort, and social support—as well as providing elemental counseling for reducing distress and promoting adaptive functioning. Energy psychology appears to be highly effective in accomplishing many of the counseling goals specified in the *Guide*. Because it gives people a potent tool for self-soothing, its ability to "calm and orient emotionally overwhelmed/distraught survivors" is immediately helpful. Because of its ability to relax individuals during an interview, as exemplified by Barbara Smith's report above, it can be a powerful tool for assessing survivors' "immediate needs and concerns." In terms of reducing distress and promoting adaptive functioning, among the most frequently reported and appreciated benefits of energy psychology by those using it in non-clinical settings is its ability to help them self-manage problematic emotions. This capacity can be applied directly (albeit great sensitivity is required) to the management of each of the psychological reactions identified in the *Guide*, including anger, guilt, shame, grief, flashbacks, avoidance and withdrawal behaviors, insomnia, depression, tendencies toward substance abuse, and stress-induced physical disorders.

While these psychological first aid measures may also cultivate coping skills which the person continues to use and apply in new contexts long after the traumatic event, helping a person *heal* from a trauma requires a different order of treatment and care. Well mapped in the survivor and PTSD literature, the most conspicuous potential contribution of energy psychology is in its apparent ability to rapidly and permanently alleviate the debilitating hyperarousal in the limbic system that is associated with stored traumatic memories and the many life situations that might trigger them. Asked how he determines if a treatment for a traumatic event has been successful, Dr. 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."

Risks and Benefits of Bringing Energy Psychology into Disaster Areas

A criticism that has been directed toward disaster relief teams employing therapies not thoroughly validated by empirical research is that unproven or controversial therapies applied in conditions which have not been rigorously studied may be doing unknown harm, at least to some individuals. Even an approach as widely endorsed by the professional community as Critical Incident Stress Debriefing had competent, caring therapists leaving unrecognized harm in their wakes. This is a most legitimate concern, and it is not easy to produce rigorous research when a therapy team goes into an area where a disaster has recently struck, particularly when the team is traveling to a culture with which it has little familiarity. The number of variables is boggling, and opportunities to set up stringently controlled research conditions are highly restricted. Add to this language barriers and the possibility of the therapy team unwittingly imposing its own social values, mores, and assumptions onto the situation, and the challenges of accurately assessing the outcomes is enormous.

However, it is possible to gather preliminary empirical evidence, even if only at the level of systematic observation rather than controlled research. A number of generalizations, for instance, can be drawn from the interviews conducted for this paper with the members and leadership of the three major teams (the Green Cross, the TFT Trauma Relief Committee, and the ACEP Humanitarian Committee) using energy psychology 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 post-deployment assessments, most often with invitations or appeals for return visits. Pierre Ilunga, the director of the El Shaddai Orphanage in Rwanda (he also serves as a university professor and holds a Ph.D. in geology), in a letter to the TFT Trauma Relief Team members who worked with the orphanage, noted simply "Our life has been changed in a better way" in requesting a return visit "with more people if possible." Local follow-up, such as by the two physicians who stayed in contact with approximately three-fourth of the first 105 individuals treated in Kosovo, has consistently indicated that the benefits of the treatment are lasting and has not produced reports that would lead to concerns about unintended harm. Often the communications from local observers indicated surprise and appreciation that the energy psychology interventions were so unexpectedly superior to other approaches, as seen in the letter above from the chief medical officer of Kosovo and the following, from an unsolicited letter of appreciation from Dwayne Thomas, M.D., Chief Executive Officer of the Medical Center of Louisiana at New Orleans. The letter was sent to members of the TFT Trauma Relief Team about a month after their first visit to New Orleans to work with the trauma that followed Katrina: "As you know, our staff have been through (and continue to experience) a significant amount of primary and secondary trauma. We have offered staff many different interventions . . . the overwhelmingly positive response to the [TFT] therapy was a welcome and delightful surprise for us all." All three of the local organizations, in fact, that had invited the Trauma Relief Team into New Orleans asked for it to return to provide additional treatment and training.

The level of confidence with which an unproven therapy can be brought into extreme circumstances is a double-edged ethical dilemma. On the one hand, strong discretion and appropriate disclaimers must be applied before an unproven approach can ethically be introduced in the wake of a disaster. On the other hand, professional ethics also require that the mental health team carefully evaluate the available therapies in selecting and applying the methods it believes will be the most effective, and existing clinical evidence for a new therapy warrants consideration even while the accumulation of experimental evidence is still in its early stages.

With energy psychology, we have a new genre of clinical tool for bringing an effective and compassionate response to those whose lives are convulsing after terrible misfortune. While we are still learning about the power, limitations, and best applications of the approach, the apparent distinctive ability of energy psychology and other body-based interventions, such as EMDR and somatic experiencing, to rapidly reorganize the neurological disruption that occurs for many people in the aftermath of severe trauma is establishing it as an important resource in our disaster response capacities.

DISASTER RELIEF ORGANIZATIONS UTILIZING ENERGY PSYCHOLOGY

Green Cross is a humanitarian relief organization founded in response to the Oklahoma City bombings in 1995. In conjunction with the Association of Traumatic Stress Specialists and the Academy of Traumatology, Green Cross trains and certifies trauma response specialists and deploys them to disaster areas worldwide. Energy psychology methods are increasingly being utilized by Green Cross trauma specialists. Some of its counselors also have specialized training in areas such as terrorism response, compassion fatigue, working with traumatized families, or organizing first-responder peer counseling. Green Cross provides information, education, consultation, training, and treatment for traumatized individuals or communities that have been affected by natural or human-caused disaster. Besides deploying trauma response teams to provide direct services, the organization also trains trauma response personnel in local settings. In Sri Lanka, for instance, more than 100 people were trained to be "Field Traumatologists" following the December, 2004, tsunami. For further information, visit Green Cross at www.gcprojects.org or the Association of Traumatic Stress Specialists at www.atss.info.

The Trauma Relief Committee (TRC) of the Association for Thought Field Therapy Foundation coordinates a team of more than 30 TFT-trained practitioners available for deployment to assist victims and workers in need during and after local and global incidents of trauma and disaster. These trauma relief volunteers have, through invitations from local governments, churches, and private groups, provided emergency and follow-up trauma relief services in the Congo, Guatemala, Kenya, Kosovo, Kuwait, Mexico, Moldavia, Nairobi, Rwanda, South Africa, Tanzania, and Thailand, as well as in the U.S. following Columbine, 9/11, and Hurricanes Rita and Katrina. Soon to be available from the TRC is a "Trauma Relief Pack" which will include a CD demonstration of TFT trauma relief techniques, a web-based TFT trauma relief video, a tear-out card describing a TFT trauma-relief protocol, and a list of emergency TFT telephone numbers and contact data to arrange for international TFT trauma team assistance and treatment. See www.atft.org.

The Humanitarian Committee of the Association for Comprehensive Energy Psychology (ACEP) conducted its initial relief work with survivors of the December, 2004, tsunami. ACEP members provided, on a volunteer basis, energy psychology treatments to some 300 individuals in Singapore, Sri Lanka, and Indonesia, where they have also trained approximately 100 local health care providers in an energy psychology approach. Materials are being translated into Singahl, and an energy psychology certification program is being developed by an affiliate group. ACEP's primary strategy is to coordinate with government and non-government agencies, health care organizations, and psychological associations to train local social service providers. Outreach teams from within all three countries are currently using energy psychology methods with tsunami victims. They have, for instance, begun to successfully apply energy psychology methods with school children whose memories of the tsunami have been interfering with their ability to concentrate. Inquiries may be directed to John Hartung, Ph.D., ACEP Humanitarian Committee Chair, jhartung@uccs.edu.

ENERGY PSYCHOLOGY IN DISASTER RELIEF

Additional Cases

Compiled and Edited by David Feinstein, Ph.D., and Norma Gairdner, M.A., H.D.

NOTE: Client names and other identifying information have been altered to protect confidentiality.

List of Case Reports:

Treatment of PTSD Following 9-11 (with video available for inspection)

Chance Survivors of Cold-Blooded Slaughter

The Nairobi Embassy Bombing

Energy Psychology within a City's Crisis Response System

When a Loved One Has Been Lost

When You Can’t Say “Trauma”

Alternative to Pain Medication

Depression in the Aftermath of Disaster

Disaster Relief Group Treatment

Group Focus on a Physical Ailment

Training Local Medical and Social Service Personnel Following Katrina

TREATMENT OF PTSD FOLLOWING 9-11
(with video available for inspection)

Reported by Mary Sise, M.S.W.

Noreen, at the time a 39-year-old single woman living in upstate New York, was on a business trip working in an office building two blocks from the World Trade Center when the first plane struck. She and her co-workers fled from their building and, like thousands of New Yorkers, began to run from the scene when the second plane struck. Noreen witnessed people jumping out of the buildings, experienced the fear and sounds in the streets, and felt the absolute terror of not knowing if the entire country was under attack.

After returning home in upstate New York, she tried to resume her work. However, the horrible images from 9-11 were regularly intruding into her awareness. She was also having nightmares and panic reactions to loud sounds. She reported having "faceless dreams" and waking in terror. One of her co-workers, whom I had treated using Thought Field Therapy, referred her to me.

My first visit with Noreen was three days after the attack (September 14). I did an initial intake and, based on that assessment, felt that Noreen was an appropriate candidate for TFT. We videotaped her sessions. The video vividly shows her tension as she begins to access the images, body sensations, and other aspects of the trapped trauma. As the TFT treatment is applied, you can visibly see her body calm. She relates how the images are losing their vividness and their power over her. She leaves the office reporting that she feels as if September 11 is over.

The following April, I received another call from Noreen. She told me that although she had been faring much better following our session, she was still having trouble with planes flying overhead and with the sound of fire engines. Our second meeting, April 8, 2002, was also videotaped. In this session, she addresses the terror of believing the country was under attack, and her fear of planes appears to be completely eliminated during the session, which also focuses on her survivor guilt as she begins to explore in new ways the personal meaning of having been so closely involved in the devastation.

Noreen's final session with me was on June 25, 2002. We scheduled this session as a follow-up for the purpose of videotaping her report of the complete elimination of all the sequela of the trauma, including nightmares, flashbacks, anxiety about planes and other noises, anxiety in crowds, anger, and survivor guilt. She expresses her gratitude for the technique and, in giving permission for the videotape to be produced and distributed, says she wants to "share it with all the world."

When she learned shortly thereafter that the international trauma expert, Bessel van der Kolk, M.D., was speaking in Albany, she asked if she could share her experience, and she was ultimately invited to address the entire audience. She described her PTSD and its treatment to several hundred professionals, answered questions, and strongly advocated for increased public awareness that people suffering from PTSD and other effects of trauma can be treated and healed.

Mary Sise, LCSW, is a social worker and TFT practitioner in Albany, New York. She is President of the Association for Comprehensive Energy Psychology. She can be contacted at msise3@aol.com. The videotape of her work with Noreen is available through www.integrativepsy.com

Return to List of Cases

CHANCE SURVIVORS OF COLD-BLOODED SLAUGHTER

Reported by Carl Johnson, Ph.D., ABPP

A small village in Kosovo was well-known for having been the site of the one of the worst atrocities during the entire war. But a small miracle was also embedded in the story. The Serbs came in, rounded up all the men, and herded them into three buildings that were built for having meetings. One building at a time, they shot the men down, and then burned the bodies. Remarkably, in each of the three meeting halls, one man survived. In each case, the survivor had been in the center of the group so was not shot, and then wound up at the bottom of the pile of bodies, and was somehow spared from the flames.

In June of 2000, about a year after this nightmare, one of the doctors I was working with took me to see if I could provide some relief to the survivors. While this was not the doctor's village, after various inquiries, we found our way to the home of one of the men. When he saw us coming, he literally ran into the corn field behind his house. The doctor yelled after him and was able to assure him that everything was going to be fine. It turned out that another therapy team had come in some time earlier and reactivated his traumas, and he had astutely sensed that we were also coming to offer help.

He finally agreed to talk with us. We sat in his backyard and shared tea and fruit while he told the long story and even went into his house to bring out photos and news clippings. I don't usually listen to long renditions of a person's story. They are often painful for the person to tell, and they aren't necessary for the treatment to proceed. But he seemed to need to tell his story before he was going to say "yes" to the treatment.

As the treatment finally began, we identified seven aspects of his experience to focus upon: 1) being herded into the building, 2) being mowed down by guns, 3) the burning of the bodies as he lay trapped beneath them, 4) the death of a family member, 5) the death of neighbors and friends, 6) the death of a house guest who happened to have the bad fortune of visiting him at the time, and 7) his feelings about having survived when no one else did.

He did not take particularly well to the 0-10 SUD (Subjective Units of Distress) Scale. For him, either there was distress, or "It is good." Each of the seven issues started with distress, and after several rounds of tapping and related procedures, got to the point where he would report "It is good." For each area of focus that involved the loss of a loved one, a multi-tiered procedure was used (see "When a Loved One Has Been Lost"). After the seventh issue, the man stated that he was healed. At this point, the man requested that I teach him the methods I had used with him.

He took us out of the house, got into the car, and navigated us to another of the three survivors. He explained the treatment to him, and we returned that evening to work with the second survivor, again with apparent success. The third survivor could not be located.

Sixteen months later, Kosovo's chief medical officer brought me to the village to interview both men, probably because the case had achieved international notoriety. Both men indicated that there had been no relapse, along with their willingness for their improvement to be shared with others who are in a position to help survivors. Eight months later—in June 2002, two years

following the treatments–my colleague Paul Oas, Ph.D., and I visited the men and learned that the treatments for both were still holding strong.

Carl Johnson, Ph.D., ABBP, is a clinical psychologist, founder and director of The Global Institute of Thought Field Therapy, and a retired PTSD specialist with the Veteran's Administration. He lives in Winchester, Virginia, and may be contacted via carl@visuallink.com

Return to List of Cases

THE NAIROBI EMBASSY BOMBING

Reported by Jenny Edwards, Ph.D., TFTdx

When I first heard about Thought Field Therapy, I knew I wanted to learn it for my work in Africa, where I teach seminars sponsored by the Carmelite Community in Nairobi. I thought the people there would benefit from learning a simple way to eliminate trauma, physical pain, anxiety, addictions, phobias, and the many other symptoms that Thought Field Therapy successfully addresses. A year later, August of 1998, I was in Nairobi conducting a two-week seminar with priests, nuns, brothers, counselors, social workers, and educators. Along with the requested curriculum, I had decided to include a small section on Thought Field Therapy.

The bombing of the U.S. Embassy in Nairobi occurred on a Friday, while we were in the seminar, about a half hour from downtown Nairobi. I had just begun teaching TFT prior to the point that we became aware of the extent of the destruction. By Monday, the students were questioning whether TFT was powerful enough to help people with traumas as severe as those caused by the bombing. I had pre-arranged to go with the Sisters on their hospital rounds after the training that day. As we went through police roadblocks and arrived at the hospital, going directly to the wards, doubts began to surface. I knew that TFT worked – but these people had been in a bombing! I followed the Sisters from ward to ward, wondering whether TFT could help with such devastation. People’s faces were filled with stitches, often with their eyes bandaged. It was unthinkable to ask them to tap on the various face and eye points (I have since learned that equivalent points on the feet can be used when necessary).

We finally came to a woman who had mostly lower body injuries. She was lying on her bed staring into space, clearly in a great deal of pain. Her shoes had been blown off by the bombing, and among other injuries, she had a lot of glass in her feet. Though she was on pain medication, the doctors had not been around to see her yet, and she rated her pain at a “10.” Since her injuries were less severe than others, I offered to “Try something that might help.” “I’ll do anything,” she said. “I’m in so much pain. I keep thinking a bomb will explode any minute in the hospital. I know it’s probably not going to happen, but I can’t get it out of my mind!”

I worked on the pain first, using the TFT pain algorithm, and her pain came down from a “10" to a “5.” But then it wouldn’t budge. It occurred to me we needed to tap for the trauma in order for the pain to go any lower. She rated the trauma as a “10,” and using the TFT complex trauma

algorithm, it came down to a “0” immediately. After that, we tapped again for the pain, and it went down to a “0.” She looked at me a little bewildered: “I’ve played the pictures of the bombing over and over in my mind, almost without stopping, since Friday. It’s really strange. Now I’m not doing that any more. I think that I’ll be able to sleep tonight.”

The Sister then came over asking me to assist another woman who had watched the first treatment and “wanted to be healed, too.” She was bandaged and her hand was hanging limp and too painful to move. She was a “10" on both trauma and pain. I decided to work on the trauma first this time, and it came down fairly quickly to a “0." Then we worked on the pain, which was already down to an “8” from clearing the trauma. Soon her pain too was down to a “0.” She began moving her hand around and the color came back to her face. Then she was smiling and laughing. Her husband, who had been watching everything, asked the Sister if TFT might help his neck pain. She said, “Of course!” By now the first woman was sitting up for the first time since the bombing, eating dinner, and also smiling and laughing with her husband. Later on, her husband reported to the Sister that since the bombing, his wife had panicked whenever he had to leave, for fear of another bombing. On this evening, however, she was fine when he left.

Back in the seminar, I started doing demonstrations with traumas my students were experiencing related to the bombing. They were amazed by the results and began sending me friends and family, including some extremely difficult cases. I then received an invitation to introduce TFT to therapists at a local counseling center. Though I had for a year felt called to share TFT in my seminar in Nairobi, I had no idea how timely it would be, or how effective.

Jenny Edwards, Ph.D., is a Board Member of the Association for Thought Field Therapy Foundation. She has taught TFT in ten countries, including Canada, Israel, Italy, Kenya, Madagascar, Mauritius, Mexico, the Philippines, South Africa, and the United States. She is a certified NLP Master Practitioner and a Clinical Hypnotherapist. She may be contacted at jedwards@fielding.edu.

Return to List of Cases

ENERGY PSYCHOLOGY WITHIN A CITY'S CRISIS RESPONSE SYSTEM

Jim McAninch was the Practitioner

Civil bodies charged with disaster relief are increasingly developing more sophisticated psychological impact response capacities. Jim McAninch is the Industrial Coordinator for Pittsburgh's Critical Incident Stress Management (CISM) team. While most CISM programs are explicitly *not* meant to provide psychotherapy or to substitute for psychotherapy, their stated goals nonetheless often include therapeutic components. The Pittsburg team’s goals, for instance, are:

1. To reduce emotional tension.

2. To facilitate normal recovery process of normal people having normal, healthy reactions to abnormal events.

3. To identify individuals who might need additional support or referral to professionals for specific care.

The calls McAninch receives generally involve fatal disasters in the workplace. McAninch, who is a member of the TFT Trauma Relief Team, has found TFT to be a powerful tool in working with individuals suffering in the aftermath of sudden trauma.

The head of Pittsburgh's CISM Team was at first highly skeptical about having McAninch utilize TFT as part of the CISM disaster response. However, enough instances have now been logged in which TFT clearly 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 Pittsburg CISM Team. Three of McAninch's documented cases follow.

Industrial Crisis Response Case # 1

McAninch was called to a site where an employee of a small company had been electrocuted. A worker had instructed his co-worker to push a panel button, and the co-worker was electrocuted on the spot. The survivor and six others watching had to deal with the horrible scene and their unsuccessful attempts to save the man's life. They were all traumatized by the horrific death. The intense odor of burning flesh remained vivid in each of their memories. For two of the witnesses, the death also caused past traumas to resurface. One recalled the gruesome car crash fatalities he'd witnessed as a tow truck operator for twenty years. The worker who had instructed that the button be pushed had years earlier found his wife dead in a snow bank. In the current disaster, after the electricity was no longer passing through his co-worker's body, he had unsuccessfully tried to resuscitate the burned man, adding to his trauma and guilt. And, as a morbid reminder, he couldn't get rid of the smell or taste of the vomit that had come into his mouth during the resuscitation effort. McAninch treated him first as the group watched. Using a TFT complex trauma algorithm, he assisted the man with his anger and guilt until the distress levels were down to "0." McAninch then had the others get into pairs and copy the treatment on themselves and on each other, until all the trauma-related emotions were all down to "0." A week later, when he returned to do follow-up, each of the survivors was able to recall and talk about the tragedy without experiencing retraumatization.

Industrial Crisis Response Case #2

A man had fallen to his death at a construction site. The entire construction team had been through an interview and defusing process, but the foremen was concerned about the well-being of one of the workers. He called McAninch to the jobsite. The worker had directly witnessed the event and couldn't sleep. He rated his anxiety level as a "10." It was soon revealed that the man had had a near-fatal fall himself a number of years earlier, and the trauma of that experience was reactivated while watching his co-worker fall to his death. Witnessing the event had left him with visible and ongoing anxiety and agitation. Using the TFT Complex Trauma Algorithm, McAninch was able to take the trauma and the anxiety down to a "0" in a matter of minutes. The resulting relief on the man's face was immediate and apparent to everyone.

Industrial Crisis Response Case #3

McAninch arrived at the site within a few hours of a train conductor being crushed to death between two railcars. Both the locomotive engineer (the train operator) and the yard master had witnessed the disaster and seen the results. McAninch was able to begin applying the TFT trauma relief techniques on the spot. Within a short time, he had treated the two witnesses and the fiancé of the deceased conductor. He offered sessions as needed over the next several weeks, preparing the engineer to return to his job by taking him around the yard and treating him at various trigger locations, including the spot where he had witnessed the violent death of his long time co-worker and friend. Interestingly, though the engineer was soon trauma-free and guilt-free regarding the accident, it wasn't until McAninch treated him for the earlier traumatic death of his mother that, as the plant manager remarked, he was again "Carrying himself with a spring in his step, looking up, and ahead."

McAninch notes how in cases of accidental death and injury such as these, unresolved traumas from a survivor's past are often activated. Treating these helps the present traumatic incident to be more easily and rapidly resolved. McAninch is currently working with the largest industrial union in North America in exploring the possibility of introducing TFT trauma techniques throughout the union.

Jim McAninch is a counselor with "Solutions to Stress, Anxiety & Toxins" in Tarentum, PA, and an Employee Assistance specialist for the United Steelworkers, Local 1138. He is a Certified Trauma Responder, a Certified Employee Assistance Professional, and a Certified TFT Practitioner (Diagnosis Level). He may be reached at jimmymac@so-sat.com.

Return to List of Cases

WHEN A LOVED ONE HAS BEEN LOST

Reported by Carl Johnson, Ph.D., ABPP

When someone has lost a loved one, the agony has many dimensions, particularly in cases of violence. I have learned to focus first on barriers to the survivor's ability to experience a spiritual closeness to the person who has been lost. Starting anywhere else fails to honor the magnitude of the loss and to recognize the natural difficulties that people have in processing the sudden, senseless death of their loved one.

I learned this in a refugee camp near Oslo, Norway, in May 1999, during the Kosovo war. It turned out to be an invaluable understanding during my subsequent nine trips to Kosovo as well for my work with survivors in Rwanda, the Congo, and other areas of warfare and ethnic violence. My visit to Norway took place nine months prior to my first trip to Kosovo. I treated an ethnic Albanian refugee for his grief following the war death of his mother. After some initial progress, the muscle tests weren't revealing any further weaknesses in his energy system, yet he

consistently reported that his SUD, which started at 10, had come down only to 5. It never got lower than that.

There are several things practitioners should assess when muscle testing and self-report measures don't correlate, but none of these accounted for my patient's stalled SUD level. Upon reflection, and after discussion with the refugee camp staff, I concluded that more than wanting relief from his traumatic suffering, the man wanted to retrieve his lost mother or, if that proved impossible, he wanted to hold onto what little he did have that remained of her: his suffering.

Death of a loved one is the most frequent trauma in areas of unnatural disaster. In Rwanda, "presenting problems" that do not include death are rare. The patient would like to be praising the positive aspects of the lost one's life, cherishing fond memories, reviewing the wise counsel received from the deceased, and going through the rest of life in a spiritual closeness with that person. Successful treatment must honor the deceased and enable the survivor to do so. It must enhance closeness between survivor and deceased.

So the "problem," the focus, becomes something like "the block to our closeness," and the treatment objective is to clear the block. When the block reaches 0, the closeness reaches 10, and the patient is at peace. Thus, the most important aspect of the traumatic event—the loss of life—is treated purely. Once the block has been cleared, my patients and I then focus on "the rest of the matter" or "any remaining horror," including the evil. I always propose to my patients that we view their issues of grief this way, and it tends to be almost unanimously appreciated everywhere I have been.

When the survivor is able to hold the beautiful memories and all the person had contributed, and talk about these, we are ready then to move on to the other horrors of the events surrounding the death and loss.

Carl Johnson, Ph.D., ABBP, is a clinical psychologist, founder and director of The Global Institute of Thought Field Therapy, and a retired PTSD specialist with the Veteran's Administration. He lives in Winchester, Virginia, and may be contacted via carl@visuallink.com

Return to List of Cases

WHEN YOU CAN'T SAY "TRAUMA"

Reported by Carl Johnson, Ph.D., ABPP

Sometimes treatment success can hang on the use of a culturally or personally-sensitive word. An ethnic Albanian who spoke English brought a former Kosovo Liberation Army soldier to my hotel. The translator said, "He's here for help with his war trauma." I explained the 0 to 10 scale and asked him to give me a number for the intensity of his trauma. The translator conferred with the man and then said, "No number, none." I asked, "Isn't he here because he is suffering from trauma?" The translator restated, "No number, no trauma."

I sensed that while the man had come for help, he was also obeying the Albanian taboo which forbids suffering in males. I decided to bypass any mention of his suffering and said to the translator, "Okay, but could you ask him to just think about the traumatic event." The response: "No traumatic event." It dawned on me that by definition, to qualify as a traumatic event, it would have had to cause a personal trauma, which he couldn't admit to. So I asked if he had had a challenging experience, a bad moment that he had overcome." To this, he could say "Yes." So I had him think about the bad moment he had overcome. I asked him if he would enjoy having a tune-up on his strong body to get it ready for his next victory, like tuning up the engine of a magnificent race car that has won but needs to have a tune-up to win again." "That would be fine." As he focused on the event he had overcome, I used TFT diagnostics to find and treat his energy disruptions. Finally when I could find no further disruptions in his energy system, I asked him if anything more had to be done or if the tune-up had been complete. He looked relaxed. Then he spoke through the translator: "He wants me to tell you he thanks you very much for healing his trauma." Once the trauma had been resolved, it was no longer an issue for him to use the word.

Carl Johnson, Ph.D., ABBP, is a clinical psychologist, founder and director of The Global Institute of Thought Field Therapy, and a retired PTSD specialist with the Veteran's Administration. He lives in Winchester, Virginia, and may be contacted via carl@visuallink.com

Return to List of Cases

ALTERNATIVE TO PAIN MEDICATION

Reported by Sophia Cayer

Sue and her husband had lost everything after Hurricane Katrina. They had no idea what was next. Her husband observed while Sue and I worked together. The session was about a month after the hurricane. In addition to all her anxieties following the trauma, and her fears about the future, she was experiencing a great deal of physical pain. She was shaking from the anxiety, and her pain was so intense that she was experiencing great difficulty using her hands or doing any physical activity. She was scheduled for a doctor's visit the following day and planned to ask for pain medication. We worked together for about 15 or 20 minutes using EFT, focusing on her anxieties and what she was experiencing physically. Not only did the shaking subside, she told me she didn't think she was going to be needing any pain medication. She was smiling, walking easier, and she said she now felt hopeful. The tears began to roll down her face as she told me that while pacing the floors during the previous night, she had asked God for an answer. She told me she was amazed at how much better she felt, and said she was sure I had been the answer to her prayer.

Sophia Cayer is an EFT "Master Practitioner" and a life coach practicing in Sarasota, Florida. She may be reached at SOPHIAEFT@msn.com

Return to List of Cases

DEPRESSION IN THE AFTERMATH OF DISASTER

Reported by Sophia Cayer

Linda had been traumatized not only by Hurricane Katrina, but also by her subsequent experiences in a shelter after she was displaced from her home. A month after the disaster, she was so depressed that she was unable to function, spending most of her time crying uncontrollably. When I sat down with her, she had one hand over her face, sobbing and unable to speak. I gently asked for permission to take her hand and see if I could help her relax. She agreed, and I began gently tapping on the energy points on her hand. Within a few moments, her tears began to subside. She was still unable to voice her experience, so I just kept tapping and talking with her. I used a specific EFT technique which offers relief without the person having to verbally describe the event. Among other issues, she was haunted by the screams and sounds of gunshots during the nights she spent in the shelter. While she was still, for the most part, unable to speak, I continued working with her, with her tears coming and going. After several minutes, her head was held high and she was able to speak. Then she smiled. Later that evening, I saw her at a gathering for survivors. Her friends, who had initially put me together with her, seemed amazed, reporting that she was her cheerful self again. I will always remember her smiles and hugs of gratitude.

Sophia Cayer is an EFT "Master Practitioner" and a life coach practicing in Sarasota, Florida. She may be reached at SOPHIAEFT@msn.com

Return to List of Cases

DISASTER RELIEF GROUP TREATMENT

Reported by Roseanna Ellis, L.M.T.

About a month following Hurricane Katrina, Roseanna Ellis was in Selma, Alabama, working with three other practitioners of EFT who had traveled there at the request of a local therapist.

Ellis met the pastor of a local church. She thought EFT might be useful for him to know about, and she started to explain it to him. The best way to explain EFT is to demonstrate it, so she inquired about his personal situation. "Compassion fatigue" is a term used for the physical and emotional exhaustion frequently seen among those who have been helping in a disaster area. The pastor acknowledged that he was feeling extremely stressed, both from compassion fatigue and also from some longstanding personal challenges. He rated his level of stress at a 10 (of 10). Within 15 minutes, his self-reported stress level was 0. Ellis "challenged" him to *make himself* feel stressed. He couldn't. Ellis observed, "If this could make years of stress go away within minutes, imagine what it will do for the trauma of the evacuees?" He invited her team of four to come to the church's Wednesday evening "family night" to work with his congregation, which was hosting a number of hurricane victims. Of approximately 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 each 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 two-hour meeting, each practitioner worked with two or three people. Because of the rapid response associated with energy interventions, each person only needed to be treated for between ten and twenty minutes.

A 52-year-old woman, for instance, who had been forced from her home, made each of the following statements, and with tears flowing, rated each as a 10 on the 10-point subjective units of distress 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 twenty minutes, focusing on these one at a time, she was calm, in control, and 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."

Another woman, who worked for a social services agency, was so overwhelmed with the increase in her case load because of Katrina that she wept while describing it, saying that her distress level was up to a 10. Within six or seven minutes, when it had dropped to a 0 while thinking of her job responsibilities, a smile crossed her face, and she shouted happily, "Bring 'em on baby, bring 'em on!" Everyone clapped and laughed.

For reasons that are not fully understood, EFT seems to help with pain and physical symptoms as well as psychological issues. One man who worked in front of the group had severe pain in his hips and knees, at a level of 10 of 10. A few minutes of tapping got his self-report down to a 5 on his hips and 3 on both knees. When he had finished, everyone saw him walk off the stage with much greater speed and ease.

Before the individual work with these people, each person in the audience identified a personal area of emotional distress and rated it from 0 to 10. They then put their own issues aside as the individual work was conducted. But with each person on the stage, the audience supported that person's work by doing the same procedures the person on stage was doing. So if the person on stage was tapping a set of acupuncture points while stating, "feeling displaced," the audience was doing the exact same tapping and making the exact same statement. Known as "Borrowing Benefits," this method is repeatedly reported to bring down the distress level for the original issue identified by the audience members, even if there is no treatment that focuses specifically

on their own issues. 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. According to Ellis, "It's a natural to use EFT with a group of people who have shared the same experience, especially one like Katrina. 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."

Roseanna Ellis, a Licensed Massage Therapist and Physical Therapy Assistant, practices EFT in New Jersey. She may be reached at wellagain@hotmail.com.

Return to List of Cases

GROUP FOCUS ON A PHYSICAL AILMENT

Reported by John Hartung, Psy.D.

My patient had barely survived the tsunami wave that took the lives of several of her family members and many of her friends. In the hospital following the disaster, her recovery from most of injuries was rapid, except for numbness in her foot that severely limited her mobility. Now, nine months later, October 2005, she was reporting to me that she was still having difficulty walking, and this interfered with her ability to work. Her physician was so frustrated with her lack of progress that he had recently recommended surgery, more out of desperation than medical justification. After nearly a year, it was clear that things were not improving on their own. While the doctor wasn't particularly hopeful that tapping some seemingly random points on the patient's skin was going to affect her mobility, he agreed to let her try an energy psychology session to see if it might make a difference.

The treatment was carried out in the context of an energy psychology training I was providing to some 20 caregivers at a tsunami site along the shores of the Indian Ocean in Sri Lanka. I asked my patient, who was also one of the trainees (many of the trainees had been directly and profoundly impacted by the tsunami), if we could do her treatment in front of the 20 trainees, and she said we could. I explained that we would start by using energy psychology to work with the emotional upset that is inevitably related to physical symptoms.

I asked her to measure the numbness in her foot on a self-report scale. She noted that it was at a maximum. She had no feeling whatsoever in her right foot, up through her ankle, and halfway up her calf. I then asked her to identify any traumatic memories associated with the tsunami. Several extremely sad memories were immediately accessible, and they responded readily to a combination of energy psychology techniques, first the Tapas posture, and then EFT. Within minutes, she was feeling much better emotionally, but she reported that the numbness in her foot remained. I then tried a variety of other energy interventions to help with the numbness, but to no avail.

About three quarters of an hour had passed. Even though I had explained to the group that if one energy psychology strategy does not produce the desired outcome we try another, I was

beginning to feel frustrated, and I thought my trainees were as well. I then acknowledged that I might not be able to help her on this day. One method I'd not tried, however, was to utilize the group to attempt to help shift her energies, a phenomenon reported by numerous practitioners. I asked the group if they would be interested in becoming more active by doing an experiment where they would offer healing to their colleague from where they were sitting. A discussion of the power of intention and the concept of distant healing ensued. It was lively, and they unanimously agreed to participate. The woman thanked them in advance.

While she sat quietly with her eyes closed, I asked all of the members of the course to hold the Tapas posture for several minutes while sending what they defined as love and positive intention to the woman. We repeated this for several more minutes. I then asked her to stand, walk, and tell us what she noticed. She said she had begun to feel sensation in her calf and ankle. We continued, with her sitting as the rest of the group tapped the EFT points, again while thinking in positive ways about the woman. After several more minutes, she reported more feeling in her foot. We continued for another 10 minutes. Each new exercise was a repeat of something I had already tried with her, so the additional component, and apparently the active one, was the increased intentional energy from the group, plus the awareness of the woman that she was being treated not by one but by 20-some "therapists." She ended her session by walking, stretching, and laughing, and she seemed totally credible when she said she could feel about 90% of the sensation she was able to feel prior to the tsunami.

Given the impoverished explanations available for why this approach might have had such a dramatic effect with a very stubborn ailment, it seemed appropriate, at this point in the training, to turn over to the group the challenge of trying to account for what they had just witnessed (and produced?). It was a rich discussion. While no one seems to have a scientifically defensible explanation of why such a treatment would work, reports of such healings are too numerous to ignore.

Although the nature of the connection between body and mind remains a mystery, the connection itself is continuously highlighted in energy psychology treatments. Persons who ask for help to resolve an upsetting emotion often report that physical aches and strains are relieved after an energy psychology session, and those who want to reduce chronic pain (whether or not a medical cause can be found) may discover that they need to revisit a traumatic memory before their pain decreases. A new term, "bodymind," has been suggested to reflect the growing recognition of this fundamental interconnectedness, though explanations for how the body and mind actually communicate lag far behind the clinical practice of therapists working in this area.

John Hartung, Psy.D., a psychologist in private practice in Colorado Springs, C0, is affiliated with the Colorado School of Professional Psychology and the Center for Creative Leadership. Author of two books on energy psychology (*Energy Psychology & EMDR* and *Reaching Further*), he is Chair of the Humanitarian Committee of the Association for Comprehensive Energy Psychology. He may be contacted via jhartung@uccs.edu.

Return to List of Cases

TRAINING LOCAL MEDICAL AND SOCIAL SERVICE PERSONNEL FOLLOWING KATRINA

Reported by Herb Ayers, M.A.

Four months following Hurricane Katrina and the levee flooding of New Orleans, a team of twelve Thought Field Therapy practitioners from eight states converged in New Orleans to provide treatment and training for storm victims. Under the auspices of the Trauma Relief Committee of the Association for Thought Field Therapy and the leadership of Nora L. Baladerian, Ph.D., the team had been invited to work with the staff of Charity Hospital, The Volunteers of America (VOA), The Louisiana State Department of Adult Protective Services (APS), and various other members of the New Orleans community.

A total of 161 people received treatment and training, including 96 hospital staff, 31 VOA volunteers, and 10 APS employees. The program was conducted at six different sites, with the largest number of participants working in an army tent at the Charity Hospital's "MASH unit" in the New Orleans Convention Center. An additional 30 state personnel were assisted with TFT through video conferencing of the APS training.

In a situation such as Katrina, local medical and social service personnel are inevitably victims of the disaster as well as helpers, and the strategy taken was to make their treatment part of their training. They had all been personally affected by the storm, suffering differing kinds of losses, including loss of home, possessions, neighborhood, job, security, and connection with family and neighbors. Their symptoms included moderate to severe depression (notably a sense of powerlessness and sense of hopelessness, aggravated by inability to sleep); high levels of anxiety, anger, rage, trauma, disappointment, and a sense of guilt (mostly survivor guilt).

Everyone participating in the training and treatment did so voluntarily. Participants were not required to disclose the problem they wished to work on, and many did not. All that was needed was disclosure of the negative emotions that they were experiencing at the time they thought of their problem. Confidentiality was diligently observed. Prior to individual treatment, the participants were given half-hour group introductions to TFT. They were also taught the "Trauma Relief algorithm," which they could use after their individual treatments as needed.

Of the twelve Trauma Relief Team practitioners who traveled to New Orleans, four held PhDs, four held MAs, two held BAs, and two did not hold academic degrees. In most cases, they used TFT "algorithms" (protocols designed for treating specific emotions), though in several instances, it was necessary to use the more advanced "diagnosis level treatment," where the interventions are formulated based on an assessment of specific energy blockages.

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 one of the practitioners, Caroline Sakai, Ph.D., on the 22 clients she treated, showed that the presenting complaints included anger, anxiety, depression, eating in order not to feel, frustration, guilt and survivor guilt, hurt, loss, loss of control, need for improved performance, overwhelm, panic, physical pain, resentment, sadness, shame, stress,

traumatization, and worry. Each problem area was rated by the client on the 1 to 10 Subjective Unites of Distress scale. Before treatment, the average (mean) score for the 51 problem areas described by the 22 clients was 8.14. After treatment, in most cases consisting of a single session of under 15 minutes, it was down to 0.76. Most clients reported wanting to learn more about how to use TFT to help themselves, their patients, and their own families.

Herb Ayers, MA, is a licensed mental health counselor in private practice at Tri-Cities in Washington State. He is certified at the diagnostic level of TFT and is on the Board of Directors of the Association for Thought Field Therapy. He may be reached at: ghgg@charter.com

Return to List of Cases

CASE COMPILATION AND EDITING:

David Feinstein, Ph.D., a clinical psychologist, is the national director of the Energy Medicine Institute. Author of seven books and more than fifty professional papers, he has taught at The Johns Hopkins University School of Medicine and Antioch College. Among his major works are *The Promise of Energy Psychology*, *The Mythic Path*, and *Rituals for Living and Dying.* His multi-media *Energy Psychology Interactive* was a recipient of the Outstanding Contribution Award from the Association for Comprehensive Energy Psychology. For further information, visit www.EnergyPsychEd.com.

Norma Gairdner, M.A., H.D., is a Certified TFT Practitioner (Diagnosis Level) in private practice in the Toronto area, working with both children and adults. She specializes in the treatment of trauma, grief, phobias, emotional distress, and acute and chronic illness. She also regularly teaches advanced personal awareness seminars in Russia. She serves as Chair of the Trauma Relief Committee of the ATFT Foundation. www.atft.org.