ENERGY PSYCHOLOGY AND THE INSTANT PHOBIA CURE

New Paradigm or the Old Razzle Dazzle?

David Feinstein, Ph.D.

Summary: This article introduces health professionals who work with psychological issues to the emerging field of energy psychology. It provides an overview of the field, covering basic concepts and procedures. It is intended to give the reader a basis to begin evaluating this new paradigm. Research and clinical evidence bearing upon clinical efficacy are presented, and plausible neurological mechanisms are discussed. The article gives a brief history of the field, mentions various energy psychology protocols, discusses indications and contraindications for clinical applications, and demonstrates a standard clinical protocol through the presentation of four case studies.

When James Reston, a New York Times reporter accompanying Henry Kissinger on a visit to Communist China in July 1971 had an acute appendicitis attack, Chinese physicians performed an emergency operation to remove Reston's appendix. His postoperative abdominal pain was successfully treated with acupuncture, a routine procedure in many Chinese hospitals. The publicity surrounding Reston's treatment, including a front page article in the Times, is credited with opening Western minds to the practice of acupuncture. Today the American Academy of Medical Acupuncture has more than 1600 physician members, and the World Health Organization lists more than 50 conditions for which acupuncture is believed to be effective.

Since the early 1980s, Western mental health practitioners have been developing protocols for applying the principles of acupuncture to psychological issues (Gallo, 2004), patterned initially on the work of California psychologist Roger Callahan and Australian psychiatrist John Diamond. Acupuncture points can be stimulated for therapeutic effect through the use of needles or heat, but less invasive procedures—such as tapping or massaging points on the surface of the skin—have also been found to produce therapeutic outcomes. This allows a broader range of practitioners to use the approach, and it allows clients to self-administer the methods back home, in conjunction with the therapy.

Because the stimulation of acupuncture points produces physical change by altering the body's electrical activity (Cho et al., 1998), the various mental health protocols that utilize acupuncture points (such as "Thought Field Therapy," "Emotional Freedom Techniques," and "Energy Diagnostic and Treatment Methods") are collectively known as "energy psychology." Energy psychology protocols generally combine the stimulation of particular electromagnetically responsive areas on the surface of the skin (Voll et al.,1983) with methods from Cognitive Behavior Therapy, including the use of imagery, self-statements, and subjective distress ratings.

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Few treatment approaches have engendered more skepticism in the therapeutic community than those proffered by energy psychology. Claims of near-instant, lasting cures with recalcitrant problems using interventions that look patently absurd and seem inexplicable have triggered skepticism in virtually every clinician who first encounters them. At the same time, growing numbers of therapists representing a wide range of theoretical backgrounds have been trained in these methods (the Association for Comprehensive Energy Psychology, for instance, has more than 600 professional members, see http://energypsych.org/) and have found that, however mysterious the mechanism of change, the approach can yield surprisingly powerful results with certain problems.

In fact, the mechanisms by which the basic procedure—tapping specific points on the skin while mentally activating a dysfunctional emotional response—may not be as incomprehensible as first appears. Energy psychology may work by producing neurological shifts in brain functioning in much the same way as neurofeedback training, a treatment that is increasingly being used for problems ranging from learning disabilities to anxiety disorders to depression to addictions (Evans & Abarbanel, 1999). Unlike psychiatric medication, which catalyzes changes through its effects on the brain's biochemistry, both energy psychology techniques and neurofeedback training have been shown to bring about changes in brain wave patterns, and these changes correspond with a reduction of symptoms (to see digitized EEG images taken before and after energy psychology treatments, visit http://www.innersource.net/energy_psych/epi_neuro_foundations.htm).

A difference between the two approaches is that neurofeedback relies on scientific instrumentation while energy psychology does not. Although this makes energy psychology more readily accessible, it perhaps makes neurofeedback training more palatable to the professional community. In addition, the explanations used in energy psychology for the reported treatment outcomes fall outside our familiar paradigms. They make no sense if we try to understand them in terms of conventional explanatory mechanisms, such as insight, cognitive restructuring, focused mental activities, reward and punishment, or the curative power of the therapeutic relationship. But if we examine the electrochemical shifts in the brain that are brought about by stimulating electrically inductive points on the skin, a coherent picture begins to emerge.

Research studies have shown that acupuncture points are more electrically responsive than other areas of the skin (which have 20 to 30 times the electrical resistance). Studies have also indicated that acupuncture points have a higher concentration of receptors sensitive to mechanical stimulation. In energy psychology, a subset of acupuncture points is stimulated, usually by tapping them while mentally activating a dysfunctional emotional response. Tapping specific acupuncture points sends signals to the brain (Cho et al., 1998), and these signals appear to be similar to those produced by the more traditional use of needles. Various studies have demonstrated that the stimulation of selected acupuncture points modulates the activities of the limbic system and other brain structures that are involved in the experiences of fear and pain (Hui et al., 2000).

The most promising hypothesis regarding the neurological mechanism by which energy psychology achieves its effects, I feel, has been proposed by Joaquín Andrade, a physician who works with anxiety and other psychiatric disorders, and who has also utilized acupuncture in his practice for more than 30 years. Andrade traces the consequences of activating a disturbing

memory while sending electrical impulses to responsive areas of the limbic system through acupoint stimulation (Andrade & Feinstein, 2004). As Joseph LeDoux's (Nader et al., 2000) research program at the Center for Neural Science at NYU has demonstrated, any time a fearful memory is brought to mind, the neural connections between the fearful image and the emotional response may be increased or decreased. The memory becomes labile when reactivated, and thus susceptible to being neurologically consolidated in a new way–its emotional power either reinforced or dissipated in the process. In energy psychology treatments, it may be that the established ability of acupuncture to deactivate areas of the brain which are involved in the experiences of fear and pain apparently takes hold during this moment of "neural plasticity."

Putting the Methods to a Public Test

I learned of energy psychology while on sabbatical from a 30-year practice in clinical psychology. I was on an extended teaching tour, assisting my wife, Donna Eden, whose book on energy medicine had put her into the public spotlight. A few of her students were psychotherapists who already utilized energy psychology. Since I was both a psychologist and involved with energy medicine, they assumed I would be well-versed in energy psychology, which is a subspecialty of energy medicine in the sense that psychiatry is a subspecialty of medicine. I was not. In fact, the first time I saw the approach used—curing a severe height phobia within the space of twenty minutes—I could hardly believe my eyes and felt skeptical that it was actually this odd method that produced this stunning result. Nor, at this point in my career was I particularly eager to take on a whole new way of working. Nonetheless, as I continued to witness the surprising results following the use of these techniques. I wanted to be able to produce the kinds of results I was seeing. I enrolled in an intensive training and certification program, hoping to master the approach. Since the procedures themselves are actually quite mechanical, if you start with a solid clinical background, they are surprisingly easy to learn.

I was still on the extended teaching tour by the time I had completed the practice requirements and was qualified to introduce the approach to clients, so I began to do my own demonstrations during the workshops. By this time, I personally knew dozens of respectable and highly trained therapists who were applying these methods in their own practices. Even so—as a licensed psychologist who was still unable to persuasively explain *why* the techniques worked–I was more than a little uneasy to find myself doing an approximation of the kind of razzle-dazzle medicine show that had struck so many professionals (myself included) as not much more credible than Barnum and Bailey spectacles. But nothing succeeds like success, and the demonstrations I gave of these methods–quite typical of the experiences of the growing numbers of practitioners who use them–seemed to amaze my audiences, much as I had been amazed when I first saw them. The following reports describe the very first three sessions I conducted in these public demonstrations. I choose them not because they are particularly unusual or extraordinary within the practice of energy psychology, but rather because they illustrate some of the most important common elements of the approach.

Acrophobia

For my very first presentation, I asked for a volunteer who had an irrational fear. The methods can be applied to a wide range of diagnoses, but phobia treatments lend themselves particularly well to demonstrations because the results can be immediately tested. Nancy, a nurse with a

lifelong fear of heights, volunteered. During a brief, personal interview, she reported having been uneasy about heights throughout her childhood, but intensely phobic of high places ever since an incident that occurred when a group from her high school toured Europe one summer. While in Dover, Nancy had gathered the courage to move close to the edge and look over the famous White Cliffs. At that moment, the teacher supervising the group came up behind her and "playfully" pushed her forward. While he obviously grabbed her before she could fall, his stunt triggered a very severe height phobia which had plagued her for almost twenty years.

The fourth floor meeting room of the hotel where we were working happened to have a deck area and a balcony overlooking the ocean. With a video camera recording the session and a group of fellow students watching, I had Nancy walk toward the balcony. She became tentative at about eight feet from the edge, and then at about five feet, she seemed to hit an invisible wall. She could not bring herself to take the next step. The video shows that she began to tremble and perspire. She reported fighting a sense of being pulled forward as she approached the edge of the balcony. Thirty minutes later, the video shows her calmly walking up to the railing, leaning over, and with a mix of shock, triumph, and disbelief, saying about her longstanding terror of heights, "It's gone!!!" Four days later, we arranged a test on a 17th floor penthouse balcony. On the tape, she appears euphoric as she reports that her primary experience of being at the balcony's edge is enjoyment of the view.

What happened in those thirty minutes? First I led Nancy through a quick, general "energy balancing." This routine, which resembles a combination of yoga and acupressure, is designed to establish a neurological receptiveness for the more focused techniques that are to follow. Then I asked Nancy to give a 0 to 10 rating on the amount of distress she felt when she thought about being near the edge of the balcony. It was a 10. I interviewed her to identify any internal conflicts she might have about overcoming her phobia, and I also utilized an "energy test" to examine this question in a different way. Derived from the field of applied kinesiology, energy tests (also known as muscle tests) are designed to assess energy flow through established pathways (which acupuncturists call meridians) by gauging the relative strength in the muscle associated with that pathway. When the client is attuned to an internal conflict about the treatment, the energy flow often becomes disturbed, weakening the muscle and allowing the energy disruption to be detected when pressure is placed on the muscle.

Treatment does not usually progress well until such conflicts are resolved. To Nancy's embarrassment, it soon become apparent that at one level she did not want to get over the phobia because if she did, she would no longer have grounds to harbor the resentment she had been holding toward her high school teacher ever since the incident. The treatment used in energy psychology for such conflicts is deceptively simple. A statement that addresses both sides of the conflict is stated (e.g., "Even though I don't want to get over this resentment, I choose to know that I can now be free of it") while massaging particular points on the body that are believed to release blocked energies. This seems to resolve the conflict, at least to the extent that it no longer interferes with treatment progress.

We then began with the first part of a basic energy psychology protocol. While stating the triggering phrase, "fear of heights," at each acupuncture point, Nancy tapped ten pre-selected points, each for a few seconds. This sequence took less than a minute and was followed by a brief series of activities—such as eye movements, humming, and counting—which are designed to activate and balance the right and left brain hemispheres simultaneously. This was followed

by another round of tapping with Nancy continuing to mentally activate the problem by stating the triggering phrase. These three sequences constitute the protocol. Following it, Nancy was again asked to rate her distress when thinking about being near the edge of the balcony. It was now down to a 6. The protocol was repeated. Now her distress level when thinking about being near the edge of the balcony was down to a 2. After one more round, it was down to 0.

At this point, a procedure that helps to anchor the gains was used. Nancy was to visualize herself going to the edge of the balcony and experiencing no fear, while at the same time using a similar tapping protocol. After she was able in her imagination to experience the desired equanimity when facing a height, she was invited to step out onto the balcony again. This time, she walked right up to the railing with no apparent difficulty. On two-year follow-up, Nancy reported that her fear of heights had not returned. In fact, she described a difficult experience of flying in a small plane that went through severe turbulence. Other passengers were crying and vomiting, she told me in an e-mail. "Before our work together, this would have been intolerable. But I stayed calm and centered."

A Fear of Snakes in South Africa

The second time I publicly demonstrated an energy psychology approach was at one of my own workshops. I was teaching a six-day residential class in South Africa. Many of the participants were leaders in their communities who had come to learn about the unconscious beliefs and motivations that shape a person’s life and impact a community. At the close of the first evening, one of the participants confided to the group that she was terrified of snakes and was afraid to walk through the grassy area which separated the meeting room from her cabin, about 100 feet away. Several participants offered to escort her. Sensing that she could rapidly be helped with this phobia, I thought this might lend itself to a compelling introduction of energy psychology to the class. I arranged—with her tense but trusting permission—for a guide at the game reserve where the workshop was being held to bring a snake into the class at 10 a.m. the next morning.

I set up the chairs so that the snake and the handler were 20 feet away from her, but within her range of vision. I asked her what it was like to have a snake in the room. She replied, "I am okay as long as I don’t look at it, but I have to tell you, I left my body two minutes ago." She was dissociating. Within less than half an hour, using virtually the same methods I used with Nancy, she was able to imagine being close to a snake without feeling fear. I asked her if she would like to walk over to the snake, still positioned across the room. As she approached it, she appeared confident. The confidence soon grew into enthusiasm as she began to comment on the snake’s beauty. She asked the handler if she could touch it. Haltingly but triumphantly, she did. She reported that she was fully present in her body. A couple of days later, she joined the group on a nature walk. As the group returned, someone asked her if being out in the bush had been difficult, given her fear of snakes. A surprised look came over her face. She had never thought about snakes once during the entire walk. Her lifelong fear had evaporated, and when I made a follow-up inquiry some six months later, it had not returned.

Claustrophobia

My third experience with a public demonstration of energy psychology was with a 37-year-old woman who had suffered a stroke seven years earlier and developed a debilitating phobia shortly after her stroke. She had been placed in an MRI machine, became fearful, began to panic, and

then complete terror took over. She had been claustrophobic ever since, to the point that she could not sleep with the lights out or even under a blanket, could not drive through a tunnel, and could not get into an elevator. Besides being enormously inconvenient, this was confidence-shattering as she worked to regain her speech. Within 20 minutes, using the same protocol described in the above two examples, her anxiety when thinking about being given an MRI went from 10+, on a scale of 0 to 10, down to 0. The best way I could think of to test her was to have her go back into her room at the resort and get into the closet. During the break, she went into the closet and her partner then turned out the lights. She stayed there five minutes with no anxiety. When she returned to report what happened to the group, she said the only problem was that she found it "boring." The rest of the group was amazed. That evening she slept with the lights out and under the covers for the first time in seven years. Her partner was elated.

Six weeks after this single session, the following e-mail arrived: "You are not going to believe this! The test of all claustrophobia tests happened to me. I got stuck in an elevator by myself for nearly an hour. In the past I would have gone nuts and clawed the door off, but I was calm and sat down on the floor and waited patiently for the repair men to arrive. . . . It was an amazing confirmation that I am no longer claustrophobic!!!!!!!! Thank you. Thank you."

Is It Really That Simple?

So, is it really that simple? Yes and no. If these three cases are representative, as I believe them to be, they indicate that with an uncomplicated phobia, a relatively mechanical approach that does not rely on insight can rapidly and permanently overcome the phobia (Wells et al., 2003). Clinical experience further suggests that the core protocol will still work with more complex phobias, but greater therapeutic finesse is required (Feinstein, 2004). For instance, if a client presents with a fear of driving which developed following a minor automobile accident, and the basic protocol is not reducing the fear, the therapist looks for other experiences that might be psychologically linked. If the person was, for instance, injured in a skiing accident as a child, and unresolved trauma connected to that experience has been activated by the more recent event, the skiing accident would become a focus of the treatment. When the contributing experiences are based on parental or other interpersonal difficulties, the approach can quickly become quite elaborate. Most practitioners of energy psychology, in fact, integrate the field's methods with the approaches they are already using.

What about issues other than phobias? Between 1988 and 2002, a team of 36 therapists from 11 allied treatment centers in Uruguay and Argentina tracked over 29,000 psychiatric patients who were being treated with a protocol that used acupoint stimulation (http://www.innersource.net/energy_psych/epi_research.htm). Besides an estimated 70 percent overall improvement rate and various informal sub-studies suggesting that the energy psychology treatments yielded markedly stronger outcomes than conventional treatments with a range of disorders, systematic interviews with the therapists identified the conditions for which energy psychology treatments seemed more effective or less effective. Overall these clinicians indicated that energy psychology interventions were most effective with anxiety disorders, reactive depression, and many of the emotional difficulties of everyday life—from unwarranted fears and anger to excessive feelings of guilt, shame, grief, jealousy, or rejection. They did not appear to be as effective with disorders that were more biologically entrenched, such as endogenous depression, bipolar disorders, personality disorders, delirium, and dementia. For anxiety disorders, the therapists' uniform impression was that no other treatment modality at

their disposal (including Cognitive Behavior Therapy combined with medication as needed) was as rapid, potent, and lasting (Andrade & Feinstein, 2004).

I do not mean to suggest that scientific investigation has established the efficacy of an energy approach. While early returns such as the South America study are encouraging, the research is still very preliminary. Nonetheless, energy approaches have no known side-effects, appear to relieve the suffering brought about by a number of psychological conditions with unusual speed and power, and the field continues to gain proponents among a wide spectrum of clinicians.

It is hard, in fact, to maintain unwavering skepticism in the face of concrete results in one's own practice, case after case after case. We live in a time of endemic anxiety, and energy psychology offers tools that are certainly unique and possibly unparalleled in their effectiveness–particularly for relieving the suffering of relatively "normal" people with nonetheless real and painful symptoms. Because the methods can be immediately self-applied in situations that evoke inappropriate emotional responses, they are often experienced by the client as being enormously empowering. Because experienced clinicians can learn the methods with relatively little additional study or risk, it seems an obvious step in staying at the cutting edge for your clients to at least give them a try.

COMMENTARY by Jay S. Efran, Ph.D.

Like most skeptics, I secretly long to believe. Perhaps that's why, as a child, I struggled so hard to accept my parents' explanation of how Santa Claus managed to appear simultaneously at both Macy's and Gimbel's. Thus, as I read Feinstein's disarming account of Energy Psychology, I find myself wanting to give the approach the benefit of the doubt. Although it has no research backing and lacks a convincing theoretical rationale, why not experiment with this apparently harmless, easy-to-learn, procedure that might produce the marvelous clinical outcomes Feinstein reports?

Ideally, as practitioners, we should be able to just sit back and wait for controlled research to render a verdict on all of these new-fangled ideas. Unfortunately, it doesn't work that way. For instance, even after a full decade of research, we still don't know which elements, if any, of Linehan's *Dialectical Behavior Therapy* are crucial to its success. The blunt truth is that our empirical studies rarely provide the kind of timely, detailed, real-world guidance practitioners need. Furthermore, in the crucible of daily practice, even those who subscribe to well-researched models, such as CBT, find themselves inventing hybrid techniques that are far removed from the plain-vanilla protocols that were tested in "hot-house" trials with rarefied client samples.

Because new methods will continue to surface at a rate that outpaces formal research, we must all develop rough-and-ready ways of coping with this constant barrage of enticing techniques and theories. My own strategy is to listen carefully to the professional gossip and, when it gets loud enough, launch my own "field research." For example, as the buzz surrounding Thought Field Therapy (TFT)—an energy approach Feinstein mentions—reached a crescendo, I arranged to attend Roger Callahan's workshop on the subject and to listen to his demonstration tape. Then, armed with a detailed description provided by Florida State University researcher Charles Figley, I worked up the courage to try it out with a few of my own clients. I succeeded in cajoling them into tapping on various parts of their anatomies and humming "Happy Birthday to You," but the

results were disappointing. Coupled with my serious reservations about the theory, that was enough to convince me to move on.

A few years later, I decided that EMDR deserved a closer look, although I thought the pseudo-neurological theories about how it worked were nonsensical. Therefore, I went to a lecture by Francine Shapiro, read her book, and perused the early research reports—pro and con. Eventually, I signed up for an EMDR course. My enthusiasm flagged a bit when, during the training, I got a glimpse of how the procedures felt from the client's perspective. It seemed to me (and to some of my colleagues at the training) that any results were probably attributable to asking the client to focus simultaneously on multiple tasks. Nevertheless, when the course ended, I dutifully waved my fingers in front of a handful of clients to see what might happen. Again, I found the outcomes unimpressive, and I decided to avoid listing "EMDR Services" on my business card.

As I have explored various techniques, I have been increasingly suspicious of results produced at public demonstrations. Thus, I wish Feinstein had reported on his work with actual clinical cases rather than workshop volunteers. My qualms began in the '60s, when I become involved with an earlier energy approach called Reevaluation Counseling (RC). RC is a catharsis-based method created by Harvey Jackins, an ex-union organizer from Seattle. Jackins' major insight was that if he could get individuals to "discharge" in association with "mis-stored" distress patterns, they would automatically and quickly free themselves of past fears and anxieties—unprocessed recordings. Moreover, crying, laughing, and tantruming under the right conditions would presumably rejuvenate the person's natural energies and enable him or her to tap effortlessly into the vast wellspring of human intelligence. Jackins' public demonstrations of these methods were galvanizing. He would invite a shy, hesitant volunteer to join him onstage and, within moments—sometimes seconds—the individual would begin sobbing, shaking as fear was "discharged," and doubling over in spasms of laughter. Afterward, the person's face would be radiant—exactly as Jackins had predicted. Many of us who witnessed these events became instant converts. Later, as I got to know members of the RC community on a first-name basis, I realized that those demonstrations didn't tell the whole story.

First, I discovered that the glow of "discharge" is short-lived. Rather than being "cured" during such demos, RC clients tended to become discharge junkies, seeking a new cathartic "fix" each week. Apparently, that reservoir of "emotional energy" needing "release" was a bottomless pit. I also learned how much easier it is to produce a dramatic "breakthrough" when a crowd is watching than during a private session. One of the first to point this out was T. X. Barber, the well-known hypnosis researcher, who noted that stage hypnotists regularly elicit striking effects that are difficult for serious researchers to duplicate in the laboratory. In other words, context matters, and quacking like a duck is easier in some settings than in others. It is as if the volunteer becomes an actor in a play, obliged to stay in role, and—if possible—to have faith in the outcome.

Public testimonials can be similarly misleading. For instance, a woman who had worked directly with Jackins in Seattle, and was one of his most fervent supporters, later tearfully admitted to a few close friends that she was more depressed than ever and had "secretly" sought the help of a traditional therapist outside the RC community. Some other RC clients with second thoughts were told that their doubts were predictable aspects of their "chronic" patterns and could best be dealt with by more sessions.

I should add that the distinction between “chronic” and “latent” patterns became, over time, an increasingly central aspect of RC theory. “Chronics” were patterns that didn’t respond as readily to mere “discharge.” Their eradication required greater perseverance and the application of more advanced protocols. I note that Feinstein makes a similar distinction between “uncomplicated phobias” and cases that will require “greater clinical finesse.” In fact, all of the energy and energy-related approaches I know about, including EMDR, seem to begin with a simple therapy formula that is later augmented by additional protocols calling for more advanced therapist training and more client sessions. Moreover, the ratio of simple to complex cases seems to change over time, so that there are fewer of the former and more of the latter. One wonders if all of these approaches, given enough time, will essentially turn into the traditional forms of therapy they were designed to replace?

AUTHOR’S RESPONSE

I appreciated the way Jan Efran established that new therapies need to be sagely and creatively evaluated until decisive empirical appraisals are available. I was less enthusiastic about his conclusion—based on observations about the misleading claims that accompany many new therapies and a sliver of personal “field research”—that energy psychology is probably more razzle dazzle than new paradigm, associating it with Harvey Jackins’ discredited Reevaluation Counseling. But unlike Jackin’s approach, and actually much more like the *Dialectical Behavior Therapy* that Efran regards as an effective modality, the therapists who are “field testing” energy psychology have considerable stature, are reporting strong results over time with complex clinical conditions, and are continuing to grow in number more than two decades after the approach was first introduced.

Efran closes by wondering “if all of these approaches, given enough time, will essentially turn into the traditional forms of therapy they were designed to replace?” But this provocative question misses the mark. Most seasoned therapists who experiment with energy psychology conclude that in complex clinical situations, energy interventions do not *replace* the approaches that already work for them. Rather, they make those approaches more effective by adding a non-invasive tool that purportedly facilitates precisely targeted neurological change, the probable active ingredient in the phobia cures.

I also want to respond to Efran’s very reasonable suggestion that I might have shared actual clinical cases rather than experiences with workshop volunteers. I admit that in selecting examples for this article, I showcased simple, dramatic scenarios. Here is how the same techniques can play out in a more complex clinical situation. I treated a 45-year-old woman who had been moderately depressed for six months and reported having become immobilized in her job. Intake interview revealed that shortly before the onset of her depression, she had been promoted from a contained role, which she had done well for many years, to a job that required substantial interchange and often debate with colleagues. When her decisions were self-directed, she did fine. But when factoring in the opinions of others, she became confused, frozen, and antagonistic.

The interview uncovered that the job shift had activated unresolved issues from an abortion she’d had when 23, following a clandestine affair with the minister of her church. She had actually been thrilled to learn of the pregnancy, but two powerful elders in the church campaigned for the abortion. After being pressured for a month, she reluctantly agreed. She never forgave herself.

Now when someone with authority tried to persuade her to change her opinion, her emotional reaction was strong, inappropriate, and mysterious to her—until she examined its historical roots.

While such an insight can be a clinical breakthrough, it is usually not in itself sufficient to bring about significant change in a deeply embedded emotional pattern. Compare the steps you might take using CBT with the following. The treatment from this point utilized the *same* basic "tapping" protocol seen with the phobia cases, but applied it to this insight. Specifically, the following issues were focused upon, one at a time: her agony immediately following the abortion, her sense of betrayal toward the minister, her anger at the elders who persuaded her to have the abortion, her anger at herself for having been swayed, her grief for the lost child, her distrust of anyone who tried to influence her, her loss of confidence and effectiveness in her work, and her difficulties fielding the opinions of her colleagues. Over the course of five sessions, each of the above issues went from a distress rating of "7" or above down to "0" just as rapidly and decisively as the three phobias were "neutralized" in the earlier examples. For each issue she was able, after 8 to 30 minutes of applying the tapping protocol, to bring the situation to mind vividly with no sense of bodily distress.

Along the way, her ability to collaborate with colleagues improved dramatically, she began to thrive in her new position, and her depression lifted. Equivalent cases by dozens of credible therapists are reported in the literature or on the Internet, and that sampling reflects a much larger pool of clinical experience. Any method that apparently shifts the somatic underpinnings of unresolved trauma and dysfunctional emotional patterns, rapidly and non-invasively, is certainly a significant development worthy of consideration.

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David Feinstein, Ph.D., is a clinical psychologist and the national director of the non-profit Energy Medicine Institute in Ashland, Oregon. Author or co-author of 6 books and over 50 professional papers, he has served on the faculties of Antioch College and The Johns Hopkins University School of Medicine. He led a 27-person team in the development of *Energy Psychology Interactive*, an award-winning book and CD-ROM training program for psychotherapists wishing to introduce energy psychology into their practices. www.EnergyPsychologyInteractive.com.

Jay Efran, Ph.D., is professor emeritus of psychology at Temple University. He is a coauthor of *Language, Structure, and Change: Frameworks of Meaning in Psychotherapy* and of *The Tao of Sobriety.* Contact: J.Efran@worldnet.att.net .