Energy Psychology: Efficacy, Speed, Mechanisms

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Abstract

Energy psychology, as most commonly practiced, combines cognitive and exposure techniques with the stimulation of prescribed acupuncture points (acupoints) by tapping on them. Most psychotherapists who utilize acupoint tapping protocols integrate them within their existing clinical frameworks. The approach has been highly controversial, with its efficacy, purported speed, and explanatory models all questioned. Nonetheless, its utilization within clinical settings and as a self-help method has continued to expand since it was introduced more than three decades ago. This paper reviews the most salient criticisms of the method and presents research and empirically based theoretical constructs that address them. More than 100 peer-reviewed outcome studies—49 of which are randomized controlled trials—provide an evidential base for evaluating the claims and criticisms surrounding the approach. This review concludes that a limited but growing body of evidence supports claims that energy psychology protocols are rapid and effective in producing beneficial outcomes in the treatment of anxiety, depression, PTSD, and possibly other conditions. Mechanisms by which acupoint tapping might bring about these treatment outcomes are also proposed.

Keywords: acupuncture, acupressure, Emotional Freedom Techniques, energy psychology, memory reconsolidation, Thought Field Therapy

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A set of clinical and self-help approaches that integrate cognitive and exposure techniques with methods drawn from ancient healing and spiritual traditions, such as acupuncture and yoga, are collectively known as “energy psychology” (Gallo, 2004). Most energy psychology protocols incorporate the stimulation of acupuncture points (acupoints) by having the client tap on them. The earliest formulation of the approach, Thought Field Therapy (TFT), and a popular derivative, Emotional Freedom Techniques (EFT), are its most widely known variations. While these methods have been investigated primarily in their manualized forms and can be applied in that manner, most licensed psychotherapists who identified themselves with energy psychology indicated, in a survey, that they integrated acupoint tapping into more conventional clinical frameworks rather than using it as a stand-alone approach (Feinstein, 2016).

Since tapping on acupoints to address psychological issues was first introduced in the 1980s, the technique has generated intense controversy and even ridicule. A commentary by Harvard psychologist Richard McNally began: “After obtaining a TFT protocol for treating phobic fear . . . we wondered whether TFT was a hoax, concocted by some clever prankster to spoof ‘fringe’ therapies” (2001, p. 1171). A critique in a prominent clinical journal characterized a paper written by a pioneer of the method as “a disjointed series of unsubstantiated assertions, ill-defined neologisms, and far-fetched case reports that blur boundaries between farce and expository prose” (Kline, 2001). Subsequent highly critical journal reviews of the approach have also appeared (Bakker, 2013, 2014; Devilly, 2005; Gaudiano, Brown, & Miller, 2012; McCaslin, 2009; Pignotti & Thyer, 2009).

Proponents, on the other hand, have claimed that acupoint tapping protocols and related methods are triggering “a paradigm shift in biomedicine” (Leskowitz, 2018, p. 525). Some have gone so far as to suggest that the approach represents a “4th Wave” of psychotherapy—purportedly more effective than psychodynamic, behavioral, or cognitive approaches—with advocates claiming strong efficacy, unusual speed, and special strengths in facilitating targeted shifts in the neural pathways that underlie psychological difficulties (Stapleton, in press).

The American Psychological Association’s (APA) response to energy psychology has wavered. In 1999, the APA banned its continuing education (CE) sponsors from offering CE credits to psychologists for courses on acupoint therapies (Murray, 1999). In 2011, the APA reversed this ban by granting CE sponsorship status to the Association for Comprehensive Energy Psychology based on peer-reviewed randomized controlled trials (RCTs) that exceeded its requirements for CE content. While numerous RCTs (e.g., Church, Hawk, et al., 2013; Connolly & Sakai, 2011; Geronilla, Minewiser, Mollon, McWilliams, & Clond, 2016; Karatzias et al., 2011) and a meta-analysis (Sebastian & Nelms, 2017) have shown strong effects when acupoint tapping protocols were used in treating PTSD, the APA’s recent guidelines for the treatment of PTSD (American Psychological Association, 2017) do not mention any acupoint
tapping protocols as recommended or even conditionally recommended treatments. Meanwhile, the National Institute for Health and Care Excellence (NICE), the governmental authority responsible for determining which treatments are allowed for given health conditions in the U.K., created a new category for treating PTSD, “Combined Somatic and Cognitive Therapy,” which includes EFT and TFT, noting evidence in support of these approaches (https://www.nice.org.uk/guidance/indevelopment/gid-ng10013/documents, retrieved September 11, 2018).

This paper describes the most salient criticisms of energy psychology and considers research and empirically based theoretical constructs that bear upon them. It begins with a brief overview of how energy psychology protocols are most commonly practiced, with particular focus on their most distinguishing feature, acupoint tapping. The criticisms and counterpoints are then organized around efficacy claims, alleged speed, and ostensible mechanisms of action.

The Approach

In a typical energy psychology treatment session, following preparatory dialogue, the client will mentally attune to a scene, emotion, sensation, or statement related to a target issue and tap on a prescribed set of acupoints (Church, 2013c). The mental focus might be, for instance, on a difficult memory, an unwanted response to a trigger, a self-defeating belief, a problematic emotion, or a sensation such as tightness in one’s throat. The operating assumption is that the tapping will methodically reduce the client’s sense of distress or arousal in relation to the area of mental focus. Before and following each round of tapping, the client rates emotional upset about the problem or a facet of it on a 0-to-10 Subjective Units of Distress (SUD) scale (after Wolpe, 1958). Based on this quick assessment of the immediate effects of the tapping, another round of tapping is done with the therapist guiding the client to keep the same focus or to move to a new focus. This new focus may highlight any of numerous aspects of a given problem (e.g., memories, self-assessments, safety assessments, beliefs, emotions, sensations). Each is identified and addressed via additional rounds of tapping (generally requiring one to three minutes) until no subjective distress is reported regarding that aspect of the problem. Additional somatic techniques, designed to have a centering effect and facilitate information processing, may be introduced at various points during a session. A brief video illustrating an acupoint tapping protocol in the treatment of a height phobia provides a glimpse into the relatively unusual procedures (http://www.innersource.net/ep/articlespublished/height-phobia-clip.html, retrieved September 10, 2018).

Usage

Clinical applications. The number of therapists incorporating acupoint tapping into their practices is unknown. A professional organization, the Association for Comprehensive Energy Psychology, was established in 1999 and has more than 1,200 dues-paying members (https://www.energypsych.org/?AboutACEPv2, retrieved August 16, 2018). A survey submitted to licensed psychotherapists on listservs—such as those for the Association of Behavioral and Cognitive Therapies and the Society for the Science of Clinical Psychology—found that 42% of
149 respondents reported that they were using or inclined to use an energy psychotherapy modality (Gaudiano et al., 2012). An estimate published in the journal *Medical Acupuncture* placed the number of psychotherapists using acupoint tapping in the “tens of thousands” (Leskowitz, 2016, p. 181). Most practitioners of energy psychology do not, however, identify it as their primarily modality (Feinstein, 2016).

**Self-help applications.** An annual online conference focusing on acupoint tapping for personal development has averaged more than 500,000 participants over each of the past 10 years (personal communication, Nick Ortner, May 18, 2018). A free *EFT Manual* has been downloaded nearly three million times (personal communication, Dawson Church, May 20, 2018). The approach has frequently been featured in national media ([https://eftuniverse.com/eft-press-releases/eft-tapping-in-the-news](https://eftuniverse.com/eft-press-releases/eft-tapping-in-the-news), retrieved August 16, 2018). Its popularity in both its therapist-administered and self-help formats, particularly in the context of the controversy surrounding it, underlines the need for an informed response and guidance from the clinical community. This paper is an attempt to contribute to that dialogue.

**Safety**

A review of clinical trials involving more than one thousand subjects found that no “adverse events” had been reported (Church, 2013a, p. 650). A survey of therapists using energy psychology in treating survivors of childhood sexual abuse reported that they preferred the approach because it is able to “relieve the trauma in a non-invasive manner [that] lessens the possibility of retraumatization” (Schulz, 2009, p. 18). A danger in the application of acupoint tapping, however, is that, as it is so easy to learn a basic protocol, people with no training in mental health care have attempted to apply it with seriously disturbed individuals, opening issues the practitioner was not capable of helping the person resolve.

**The Somatic Component of Energy Psychology**

Discussing how he came to utilize somatic interventions in treating trauma, Eric Leskowitz reflected:

I began my career as a psychiatrist in 1983 at the Veterans Administration (VA) Outpatient Clinic in Boston, MA. At that time, psychiatric treatment of PTSD largely consisted of supportive listening as veterans retold their war stories, either one-on-one or in peer groups. The hope was that, somehow, the inevitable emotional catharsis of sharing long-forgotten stories would ease the veterans' emotional burdens. Mild anxiolytics such as Valium® (diazepam) were also part of the picture, but the Freudian psychoanalytic model still held sway: Make the unconscious conscious, and all would be well. . . . However, that is not how things worked out. Telling and retelling war stories actually made things worse because it reactivated the original trauma response again and again. (2016, p. 181).

Bessel van der Kolk’s (1994) seminal paper, “The Body Keeps the Score: Approaches to the Psychobiology of Posttraumatic Stress Disorder,” proposed a biological basis for Leskowitz’
experience that “talk therapy is not enough.” Van der Kolk pointed to evidence that “trauma is stored in somatic memory and expressed as changes in the biological stress response [that are subsequently] relatively impervious to change” (p. 253). Therapies have been emerging that build upon recent neurological findings and suggest the importance of nonverbal, body-oriented, “bottom-up” approaches to serious emotional disorders (e.g., Minton, Ogden, & Pain, 2006). Nonetheless, treatments that are effective in directly targeting the somatic underpinnings of trauma have not—beyond cursory somatic interventions such as breath control, muscle relaxation, and focusing on bodily sensations—been widely utilized. While the “standard of care” therapies for PTSD—cognitive processing therapy and prolonged exposure—are proving to be more effective than talk therapy alone, a *JAMA (Journal of the American Medical Association)* review of the two approaches with military and veteran populations, conducted between 1980 and 2015, found that while many patients received some benefit, approximately two thirds retained their PTSD diagnosis after completing treatment (Steenkamp, Litz, Hoge, & Marmar, 2015).

The physiological dimensions of trauma-based disorders can be directly addressed by therapies that include explicit somatic components. *The Handbook of Body Psychotherapy and Somatic Psychology* (Marlock, Weiss, Young, & Soth, 2015) provides a comprehensive overview of psychotherapies that build upon the potential role of somatic interventions for overcoming psychological distress and mental illness. Body-mind therapies date back to the work of Elsa Gindler and Wilhelm Reich (Marlock et al., 2015) and extend to modern iterations such as “somatic experiencing” (Paynel, Levine, & Crane-Godreaul, 2015) and “sensory-motor processing” (Gene-Cos, Fisher, Ogden, & Cantrell, 2016). Each represents a unified body-mind perspective, based on the complementary premises that physical conditions affect mental health and mental conditions affect physical health. Acupoint tapping is a gentle somatic intervention generating electrical signals that have been shown to rapidly disrupt the neurological underpinnings of psychological symptoms (Stapleton, in press).

**Roots in Acupuncture**

Acupoint tapping protocols draw from the ancient Chinese healing system of acupuncture. The reception of acupuncture in the West has been mixed, with strong detractors (see, for instance, the opinion-setting anthology edited by Ernst and White, 1999, and an influential editorial by Hall, 2011). On the other hand, 1,300 physicians are members of the American Academy of Medical Acupuncture (https://www.medicalacupuncture.org/, retrieved August 18, 2018) and hundreds of scientific papers are published in English each year in more than a dozen peer-reviewed journals that are devoted to acupuncture and related topics. Interpretations of this vast literature regarding the effectiveness of the method have been equivocal. One of the most comprehensive and stringent reviews to date is the report of the Acupuncture Evidence Project (McDonald & Janz, 2017). It drew upon 136 systematic reviews and meta-analyses (including extensive investigations by the World Health Organization and the United States Department of Veterans Affairs as well as 27 Cochrane reviews) in examining pooled data from more than 1,000 RCTs. Although the report was published as a monograph and thus was not peer-reviewed, the studies it assessed were peer-reviewed, and the authors evaluated them according to the National Health and Medical Research Council criteria for assessing “levels of evidence” and the Cochrane GRADE criteria for assessing risk of study bias.
Applying these criteria, the quality of evidence for the efficacy of 122 medical conditions across 14 broad clinical areas that had been investigated in the various reviews was evaluated. “Moderate” to “high quality” evidence of beneficial effects of acupuncture was found with 46 conditions, including several psychiatric disorders. Acupuncture was also shown to be effective as an adjunct to medication in the treatment of depression, schizophrenia, and hypertension. At least some supportive evidence was found for 117 of the 122 conditions. The studies included in the various reviews were all conducted between 2005 and 2016. The reviewers noted a trend that, during the 11-year period that was considered, the quality of evidence had increased significantly for 24 of the conditions.

**Acupuncture vs. Tapping on Acupuncture Points**

Energy psychology protocols stimulate acupuncture points by percussing the fingertips on the skin (tapping), a form of acupressure. In acupressure, traditional acupuncture points are manually stimulated for therapeutic effects (Lee & Frazier, 2011). A double-blind study comparing penetration by acupuncture needles with non-penetrating pressure found equivalent clinical improvements for each intervention (Takakura & Yajima, 2009). Informal studies have actually shown tapping to be superior to needling in the treatment of anxiety disorders (Andrade & Feinstein, 2004), presumably because of the flexibility of tapping compared to needling in being able to make quick adjustments that are attuned to the client’s emerging experiences as the session progresses. Although the term “acupressure” might give the impression that continual pressure is being applied, tapping on acupuncture points is another traditional form of acupressure. While the published research on acupuncture is substantially more extensive than that on acupressure, a growing literature is showing acupressure to be effective as well for a range of physical and emotional conditions (e.g., Au et al., 2015; Chen, Chien, & Liu, 2013; Gach & Henning, 2004; Helmreich, Shiao, & Dune, 2006). Differing from the conventional uses of acupressure, energy psychology protocols also utilize imaginal exposure and cognitive restructuring within a context oriented toward emotional healing and psychological development.

**The Mechanics of Acupoint Tapping**

The process by which tapping on acupoints produces electrical signals involves a well-established mechanism called “mechanosensory transduction,” by which cells are able to convert a mechanical stimulus (e.g., needling or tapping) into electrical activity (Gillespie & Walker, 2001). At least some acupuncture points have also been shown to have less electrical resistance, and thus greater electrical conductivity, than adjacent points (Li et al., 2012). The path by which the signals generated by acupoint stimulation move through the body has been mapped, based on imaging studies, as being along the fascia, the soft tissue component of connective tissue, which forms a whole-body matrix of structural support (Bai et al., 2011; Finando & Finando, 2012). A strong correspondence has, in fact, been found between the pathways on which acupuncture points are purportedly situated (described as “meridians” in acupuncture theory) and the body’s interstitial connective tissue (Langevin & Yandow, 2002). While a major criticism of acupuncture has been based on the difficulty of establishing correspondence between putative meridian pathways and anatomical structures (e.g., McCaslin, 2009), these imaging studies are beginning to resolve that question (Langevin & Wayne, 2018) and shed light on other puzzles.
For instance, because of the semiconductive properties of the collagen comprising much of the connective tissue, the signals produced by tapping on acupoints can plausibly be sent to specific areas of the body more rapidly and directly than if they needed to travel through the nervous system, neuron-to-synapse-to-neuron (Oschman, 2003).

**Efficacy**

Seventeen years after a popular book, *The Five Minute Phobia Cure* (Callahan, 1985), provocatively introduced acupoint tapping as a psychological treatment, not a single peer-reviewed clinical trial showed acupoint tapping to be effective in helping overcome phobias or, for that matter, any other psychological problem. With enthusiastic proclamations but no scientific backing, the view that a hoax was being perpetrated on the public had become a matter of concern to the clinical community (Feinstein, 2005). The first RCT investigating the approach was not published until 2003. Wells, Polgase, Andrews, Carrington, and Baker (2003) reported that a 30-minute treatment using an acupoint tapping protocol reduced fear to a significantly greater degree than a non-tapping comparison. For the next several years, additional high-quality peer-reviewed clinical trials were slow to come. The past decade has, however, seen a spate of studies of the approach for treating a variety of disorders. Their reception by the clinical community has been mixed. The existing efficacy evidence is briefly surveyed here.

**Clinical Trials**

As of August 2018, 101 clinical trials investigating the application of acupoint tapping protocols had been published in peer-reviewed journals and were listed in the research area of the Association for Comprehensive Energy Psychology’s website (www.energypsych.org). The compilation, containing studies originating in more than a dozen countries, builds upon systematic literature searches conducted for reviews assessing the approach (sources typically included MEDLINE/PubMed, PsycINFO, Google Scholar, and references from retrieved papers) as well as continual updates from interested researchers. Beyond the journal reports, an additional 24 studies or commentaries are listed that were retrieved from the “grey literature” (e.g., doctoral dissertations and conference proceedings). Of the 101 published outcome studies, 49 were RCTs examining the use of the method with a wide range of conditions, including anxiety, PTSD, specific phobias, depression, weight issues, sleep disorders, physical pain, fibromyalgia, and athletic performance.

Standardized written instruments or other evaluations such as structured clinical interviews or observed behavioral changes showed significant pre/posttreatment improvements in all of the studies reported in the grey literature and all but one of the 101 published clinical trials. In the study with null results, Moritz et al. (2011) offered individuals already participating in online OCD (obsessive-compulsive disorder) support groups a self-help manual for using acupoint tapping with OCD as well as access to two video demonstrations, but no face-to-face or other contact with a therapist. While 39% of participants credited the tutorial for decreased OCD symptoms and 72% indicated that they would continue to use the approach in the future, improvement on standardized measures of OCD had not reached significance four weeks after the self-help material was introduced. It is, of course, possible that additional clinical trials with null or negative results were conducted but not reported, constituting undetected publication bias.
Two investigations, consistent with the majority of the outcome studies, found statistically significant improvement following acupoint tapping, but the investigators attributed these outcomes to other factors than the tapping (Pignotti, 2005; Waite & Holder, 2003).

Meta-analytic Reviews

Meta-analyses have been conducted on energy psychology treatments of anxiety, PTSD, and depression, respectively. Of 14 RCTs ($N = 658$) examining acupoint tapping in the treatment of anxiety disorders, a combined pre- to posttreatment effect size of 1.23 was found (.8 is considered a “large effect”). The combined pre- to posttreatment effect size for the comparison conditions was .41 (Clond, 2016). A meta-analysis of seven RCTs ($N = 247$) investigating the treatment of PTSD found a pre- to posttreatment effect size of 2.96 (Sebastian & Nelms, 2017). A meta-analysis of 12 RCTs ($N = 398$) investigating the approach with depression showed an overall effect size of 1.85 (Nelms & Castel, 2016). A fourth meta-analysis, reviewing 18 studies addressing a variety of conditions, found a moderate overall effect size of .66 (Gilomen & Lee, 2015). A fifth meta-analysis, though not an efficacy study per se (it was investigating active ingredients, a question we will turn to later), found large effect sizes in the studies it reviewed (Church, Stapleton, Yang, & Gallo, 2018).

Design Quality

The conclusions that can be drawn from meta-analysis are, of course, only as reliable as the information being analyzed, and acupoint tapping studies have varied widely in quality. Many of the investigations lacked features of more robust designs, such as large Ns, precisely defined diagnostic populations, systematic procedures for insuring compliance with treatment manuals, and diagnostic pre- and posttreatment interviews to augment validated written instruments. Also, the principal investigators were often proponents of the approach, a potential source of strong bias.

More rigorous studies by disinterested investigators are clearly needed to corroborate or challenge the existing efficacy research. Nonetheless, an analysis of adherence to the standards set by Division 12 of the APA for “empirically supported treatments”—the standards that were in effect when the vast majority of the studies were conducted [http://www.div12.org/PsychologicalTreatments/index.html](http://www.div12.org/PsychologicalTreatments/index.html), retrieved February 12, 2014)—showed that 15 RCTs investigating acupoint tapping met all seven of the essential criteria of the Division 12 standards (Church, Feinstein, Palmer-Hoffman, Stein, & Tranguch, 2014). These essential criteria included (a) randomization, (b) sample sizes that are adequate for detecting statistically significant differences, (c) clearly defined treatment populations, (d) assessment tools with established reliability and validity, (e) blinded assessments, (f) use of treatment manuals or other means for ensuring uniform interventions, and (g) enough data provided in the paper reporting the clinical trial that the study’s conclusions can be reviewed for appropriateness. The 15 studies meeting these criteria represented nearly half of the energy psychology RCTs published at the time.

Beyond variation in the quality of the studies being analyzed, another potential weakness in the meta-analytic reviews is that the comparison conditions were most frequently wait lists,
treatment-as-usual, or placebo interventions rather than evidence-based therapies. Most psychological treatments will show some positive effect based on factors shared by all therapies, such as a therapeutic alliance and the expectation that the process will result in improvement (Wampold, 2015). “Head-to-head” comparisons with therapies whose effectiveness has been empirically verified have become a standard for establishing the relative effectiveness of a new treatment.

**Head-to-Head Comparisons**

Nine studies have compared energy psychology treatments with an evidence-based comparison condition. Seven compared treatment outcomes between energy psychology and cognitive behavior therapy (CBT) for conditions including agoraphobia (Irgens et al., 2017), anxiety in teens (Gaesser & Karan, 2017), depression/anxiety (Chatwin, Stapleton, Porter, Devine, & Sheldon, 2016), food cravings (Stapleton, Bannatyne, Porter, Urzi, & Sheldon, 2016), generalized anxiety disorder (Andrade & Feinstein, 2014), test-taking anxiety (Benor, Ledger, Toussaint, Hett, & Zaccaro, 2009), and trauma following gender violence (Nemiro & Papworth, 2015). In each of these studies, the energy psychology outcomes were at least equivalent to the CBT outcomes and some exceeded them in some measures, particularly in speed. In a comparison with Eye Movement Desensitization and Reprocessing (EMDR) in the treatment of PTSD, energy psychology protocols showed approximate equivalency (Karatzias et al., 2011). In a comparison with Narrative Exposure Therapy for the treatment of PTSD, EFT was significantly more effective in reducing hyperarousal, anxiety, and depression symptoms, with reductions following the EFT treatments remaining consistent at 12-month follow-up (Al-Hadethe, Hunt, Al-Qaysi, & Thomas, 2015).

The principal investigators in six of these nine studies, however, had some allegiance to energy psychology, and three of the studies were presented as pilot studies. Additional well-designed head-to-head studies conducted by impartial investigators are clearly needed to make informed comparisons of energy psychology with other treatments. Meanwhile, a meta-analysis of 32 studies of treatment outcomes with children and adults following human-made and natural disasters provides another basis for comparison of a tapping protocol with recognized treatments (Brown et al., 2017). Narrative Exposure Therapy, CBT, EMDR, and trauma-oriented classroom interventions constituted the vast majority of the included treatments. Only one of the 32 studies investigated an energy psychology protocol (TFT). Effect sizes ranged from 0.09 to 4.19, with the average effect size across the groups being large (1.47). The strongest effect size of the 32 treatments was produced by TFT (4.19).

**Active Ingredients**

The question of whether acupoint tapping—the most prominent yet most controversial feature of energy psychology protocols—is an essential or even active ingredient in the reported clinical outcomes has been a focus of critical reviews of the approach (e.g., Bakker, 2013; Gaudiano et al., 2012). In addition to the clinical ingredients shared by all psychotherapies, energy psychology protocols utilize exposure techniques and cognitive interventions. Of the various components, tapping on one’s skin might seem the ingredient that is the least likely to be a therapeutic agent. It is certainly the strangest-looking and least aligned with existing
explanatory models about what makes psychotherapy effective. What is the evidence for the clinical efficacy of acupoint tapping independent of the protocol’s other features?

This type of inquiry is generally addressed with *dismantling* or *component* studies, which eliminate or replace elements of a treatment and compare outcomes with the standard treatment protocol (Papa & Follette, 2015). A review of six component studies involving EFT protocols with and without acupoint tapping concluded that acupoint tapping is an active ingredient, independent of placebo, nonspecific therapeutic effects, or other clinical factors (Church, Stapleton, et al., 2018). Two of the comparative studies substituted tapping on acupoints with tapping on non-acupuncture (“sham”) points in otherwise identical EFT protocols and found that tapping on the acupuncture points produced significantly stronger emotional benefits than tapping on the sham points (Reynolds, 2015; Rogers & Sears, 2014). Church and Nelms (2016) substituted diaphragmatic breathing for acupoint tapping in otherwise identical 30-minute EFT protocols and found the acupoint tapping condition to produce greater long-term emotional benefits as well as sustained improvements in a targeted physical condition.

The first attempt to isolate whether tapping is an active ingredient in an energy psychology protocol (Waite & Holder, 2003) has been interpreted both as demonstrating that tapping *is* an active ingredient (Baker, Carrington & Putilin, 2009; Pasahow, 2010) and that it *is not* an active ingredient (Gaudiano et al., 2012; Pignotti & Thyer, 2009). Three tapping variations—tapping on acupoints, tapping on sham points, and tapping on a doll—each produced significant reductions in fear, while a no-tapping control group showed no change. An explanation that has been put forth for the conflicting interpretations is that all three tapping conditions inadvertently stimulated an acupuncture point on the forefinger (Large Intestine 1) that is used in the treatment of “mental restlessness” (Ross, 1995, p. 306). Reynolds (2015) was the first to devise a sham tapping research strategy that ensures that active acupoints (hundreds are identified in the acupuncture literature) are not being stimulated.

**Summary of Efficacy Evidence**

While only a cursory overview of the efficacy research is presented above, substantial reviews of existing studies and their strengths and weaknesses can be found in the five meta-analytic reviews. At this point, a cautious deduction from existing meta-analyses, RCTs, other clinical trials, and research trends is that the current literature constitutes a limited but growing body of evidence that supports claims that acupoint tapping protocols are effective in producing beneficial outcomes in the treatment of anxiety, depression, PTSD, and possibly other conditions.

**Purported Speed**

Although the title of the 1985 *Five Minute Phobia Cure* was highly provocative and overstated, evidence has since accumulated suggesting that the approach may be unusually rapid. After a single acupoint tapping session of 30 to 60 minutes, significant therapeutic changes—in relation to comparison conditions—have been measured in brain-wave patterns (Swingle, 2010), cortisol levels (Church, Yount, & Brooks, 2012), the expression of genes involved in learning and emotional regulation (Maharaj, 2016), frozen shoulder (Church & Nelms, 2016), fear of
small animals (Wells et al., 2003), agoraphobia (Lambrou, Pratt, & Chevalier, 2003), various other psychological conditions (Church, 2013b), and PTSD (Connolly & Sakai, 2011).

For instance, 16 abused male adolescents, all scoring above the PTSD range on a standardized symptom inventory, were randomly assigned to an EFT treatment group or a wait-list condition (Church, Piña, Reategui, & Brooks, 2011). Each of the eight participants in the treatment group no longer met the inventory’s PTSD criteria 30 days after a single treatment session. None in the wait-list control group showed significant change. In a larger study, 145 traumatized adult survivors of the Rwanda genocide more than a decade earlier were randomly assigned to a single-session TFT group or a wait-list control (Connolly & Sakai, 2011). Pre/posttreatment scores on two standardized PTSD self-inventories showed improvements that were significant beyond the .001 level on all scales (e.g., anxious arousal, depression, irritability, intrusive experiences, defensive avoidance, dissociation), and the improvements held on two-year follow-up. Participants in two other studies also showed significant relief of PTSD symptoms after a single tapping session (Connolly, Roe-Sepowitz, Sakai, & Edwards, 2013; Sakai, Connolly, & Oas, 2010).

Acupoint tapping practitioners are not, however, suggesting that a single-session format is adequate for treating PTSD. Investigators in all four single-session studies were limited by practical constraints, and when queried by the current author, each acknowledged that additional sessions could have benefitted at least some if not most of the participants. Nonetheless, the number of sessions that have been required for successfully treating PTSD with energy psychology protocols in existing investigations is relatively low. A study of the use of EFT with PTSD that allowed subjects to receive up to eight treatment sessions within a public health service facility found voluntary termination of treatment after an average of 3.8 sessions, with a large overall effect size (1.0) on posttreatment measures (Karatzias et al., 2011). The first major study of energy psychology in the treatment of veterans with PTSD had a low dropout rate and found that only 14% still had the disorder after six one-hour tapping sessions (Church, Hawk, et al., 2013), a study that has been replicated with similar findings (Geronilla et al., 2016).

By way of contrast, cognitive behavior therapy (CBT) and its variations, which are the standards of care for treating PTSD (American Psychological Association, 2017), average 12 to 16 treatment sessions (http://www.apa.org/ptsd-guideline/treatments/cognitive-behavioral-therapy.aspx, retrieved August 16, 2018), and as many as two thirds of patients completing a course of CBT still met PTSD diagnostic criteria after treatment (Steenkamp et al., 2015). High dropout rates have also been a problem in CBT treatments of PTSD, particularly in “real world” (as contrasted with clinical trial) conditions (Najavits, 2015). Meanwhile, three well-designed studies comparing acupoint tapping and CBT treatments showed at least equivalent outcomes but with fewer sessions required by tapping to achieve those outcomes (Gaesser & Karan, 2017; Irgens et al., 2017; Stapleton et al., 2016).

To summarize, three lines of evidence were briefly surveyed that bear upon the speed of energy psychology protocols: (a) after a single energy psychology session, significant health-associated changes were found in biological markers involving hormone levels, gene expression, and brain-wave patterns as well as a variety of clinical symptoms; (b) unusually rapid amelioration of PTSD was found in several studies; and (c) comparisons with CBT treatments
showed at least equivalent outcomes in fewer sessions. Taken together, these findings suggest that energy psychology treatments have produced rapid therapeutic effects in standard biological markers such as cortisol production and gene expression as well as in several clinical conditions.

Mechanisms

Perhaps the largest obstacle to the acceptance of energy psychology by the professional community has been the seeming implausibility of any claim that tapping on the skin can help overcome serious psychological problems. The following discussion examines neurological mechanisms that lead to a plausible explanatory framework for such claims.

Clinical outcomes following acupoint tapping have been explained in terms of “meridians,” “chakras,” “blocked chi,” “yin/yang imbalances,” and “thought field perturbations.” While “biofield therapies” are increasingly being employed in health care (Guarneri & King, 2015), these concepts are generally not accepted by the scientific community. Their appearance in the early energy psychology literature led, in fact, to the approach being branded as a pseudoscience. A published commentary reviewing the first paper on energy psychology to appear in an APA journal asserted: “Nowhere in the history of psychology, medicine, anatomy, physiology, or biology is there any evidence that human beings have an energy field . . . Energy psychology advocates are not able to provide any evidence that the changes seen in any of their clients are related to acupressure, meridian points, or energy fields” (McCaslin, 2009, pp. 253–254).

Beyond the plethora of studies that contradict this assertion (e.g., Collinge, 1998; Swanson, 2010), advances in neuroscience allow the mechanisms of acupoint tapping protocols to be explained with no recourse to concepts from metaphysics or ancient healing traditions. A range of hormonal and neurological shifts reliably follow acupoint tapping sessions. For instance, reductions in cortisol production (Church, Yount, & Brooks, 2012), normalization of brain-wave patterns (Lambrou et al., 2003; Swingle, 2010), shifts in blood flow within the brain (Stapleton et al., 2018), and changes in gene expression (Church, Yount, Rachlin, Fox, & Nelms, 2018; Maharaj, 2016) have all been measured following energy psychology treatments.

Biological changes that can be detected after a treatment may, however, be correlational rather than causal. For instance, changes in the production of hormones such as cortisol typically follow rather than cause the reduction of limbic system activation. The decreased cortisol production is secondary and could be a misleading target for understanding the causal mechanisms of acupoint tapping. The following discussion is organized around two testable cause-effect hypotheses that are consistent with current neurological understanding.

Hypothesis 1: Acupoint Tapping Sends Regulating Signals to Brain Areas Aroused by the Imaginal Exposure Component of the Protocol

One of the earliest neurological explanations of how acupoint tapping might produce therapeutic change was based on the findings of a 10-year research program at Harvard Medical School investigating the effects of acupuncture. Among the research team’s conclusions was that stimulating selected acupoints generates extensive deactivation in the amygdala and other areas
of the limbic system: “Functional MRI and PET studies on acupuncture at commonly used acupuncture points have demonstrated significant modulatory effects on the limbic system, paralimbic, and subcortical gray structures” (Hui et al., 2005, p. 496). The premise based on these findings, as applied to energy psychology, was that “manually stimulating a set of acupuncture points . . . decreases activation signals in areas of the amygdala and other brain structures involved with fear” (Feinstein, 2008). These effects, as shown by the fMRI (functional magnetic resonance imagining) and PET (positron emission tomography) studies, are virtually instantaneous.

**Combining psychological exposure with acupoint tapping.** The imaging studies offered a plausible explanation for one of the most puzzling features of acupoint tapping, which is why it seems to work so quickly. As with other forms of psychological exposure, the client mentally activates a feared situation, an unresolved traumatic memory, or other emotional trigger. Simply bringing to mind a stressful scene will produce a threat response in the amygdala and related areas of the limbic system (Phelps & LeDoux, 2005). But unlike in other exposure techniques, acupoint tapping is also performed, so the limbic system is simultaneously receiving opposing messages: activating signals produced by the psychological exposure and deactivating signals produced by the tapping. The activating signals are habitual responses based on old learnings. The deactivating signals provide new information. With repeated rounds of acupoint tapping, the continual influx of deactivating signals begins to dominate, so the image can be held without the emotional response it previously evoked. This may also account for the low risk of abreaction associated with the method (Church, 2013a; Schulz, 2009). Arousal is quickly reduced while the trigger is still active. This is usually a vivid moment in the client’s experience. The expected aversive emotional charge does not accompany the visualized scene, and therapists who use the approach are accustomed to witnessing the surprised sense of relief that often occurs during acupoint tapping sessions. (A 10-minute video illustrating such surprise in four combat veterans as their PTSD-based responses recede can be viewed at [http://www.innersource.net/ep/index.php?option=com_content&view=article&id=60](http://www.innersource.net/ep/index.php?option=com_content&view=article&id=60), retrieved September 10, 2018).

**Changes in neural arousal.** A recent comparison of fMRI images prior to and following a course of energy psychology treatments lends support to the premise that acupoint tapping can send signals that directly influence brain activity in targeted ways. Stapleton et al. (2018) compared pretreatment with posttreatment brain scans of 10 obese participants from a four-week (two hours per week) EFT program designed to reduce food cravings. Photos of high-calorie foods such as pizza, hamburgers with fries, chocolate chip cookies, and ice cream sundaes were shown while participants were in the fMRI scanner and asked to “think” about eating the food. The areas of the participants’ brains that were activated (i.e., increased blood flow) were recorded. Following the treatment, the same photos were again shown and areas of brain activation recorded. Significant decreases between the first and second scans were found in the activation of the lateral orbitofrontal cortex, a part of the brain’s reward system that is associated with food cravings. Decreases were also found in the superior temporal gyrus, which among other functions is associated with food recognition. For some participants, no posttreatment activation was detected in some of these areas. Participants experienced corresponding decreases in their actual cravings for carbohydrates and fast foods. No changes in brain activation or subjective food cravings were found in a no-treatment control group over the four-week period.
**Sending regulating signals to targeted brain areas.** Regulating signals may give instructions to increase or decrease activity in a particular region of the brain. Some acupoints, called “sedation points,” are used for their deactivating or calming effects. Others, called “tonification points,” are used for their activating or stimulating effects (Moncayo & Moncayo, 2009). The actions of such points have not been differentiated in energy psychology studies, but even if “sedation” and “tonification” points only serve as metaphors, either type of action may be required, depending on the targeted outcome. Deactivating signals are needed when decreased activation is desired in brain areas involved with, for instance, fear or food cravings. Activating signals are needed when greater activation is desired, such as in areas of the brain having to do with self-confidence or discernment. Laboratory investigations following energy psychology treatments correspond with both types of outcomes. For instance, magnetoencephalography images (which map brain activity) before and after an EFT session that successfully treated a fear of flying showed that the treatment downregulated activity in limbic and cerebellar regions implicated in the fear response while increasing activity in executive regions that mediate limbic responses to stressful stimuli (Di Rienzo et al., 2018).

These imaging studies showing that acupoint tapping changes arousal levels in areas of the brain related to targeted problems also correspond with clinical experience. In energy psychology protocols, the client brings to mind situations that evoke unwanted psychological responses (such as anger or anxiety) or desired responses (such as enhanced ability to manage emotions). The acupoint tapping appears to send regulating signals to brain regions that have been aroused by this brief exposure. By the selection of scenes for the client’s attention during the acupoint tapping, energy psychology practitioners are able to “aim” the regulating signals at targeted issues with considerable precision. This is consistent with the hypothesis: acupoint tapping sends regulating signals to brain areas aroused by the imaginal exposure component of the protocol. Imaging studies using energy psychology with additional conditions are underway and will lend confirming or disconfirming evidence to this premise.

**Hypothesis 2: Acupoint Tapping Protocols Can, with Unusual Efficiency, Disrupt and Revise or Replace Old Learnings That Are No Longer Adaptive**

While evidence that acupoint tapping rapidly modulates activity in targeted brain areas is appearing, the question remains: Why would these changes persist? Even if, for instance, applying acupoint tapping while bringing to mind a stimulus that evokes irrational fear reduces limbic system arousal in the moment, why would the person’s fear not return the next time the stimulus is encountered? Yet follow-up investigations of energy psychology treatments have consistently shown symptomatic improvements to be durable (Church, 2013a).

**The neural pathways that maintain maladaptive feelings, thoughts, and behavior.** Up until the 1990s, neuroscientists agreed that once a deep emotional learning was acquired, it was “forever” (Grecucci1, Frederickson, & Job, 2017, para. 7). The concept of neuroplasticity did not emerge until the second half of the 20th century (e.g., Bennett, Diamond, Krech, & Rosenzweig, 1964), and studies of the brain mechanisms that have evolved for decisively countering entrenched maladaptive learnings only began appearing in the 1990s (e.g., Nader, Schafe, & LeDoux, 2000). The “forever” assumption was based on the observation that after a
remembered experience or an old learning was mentally accessed, it was reintegrated into the cognitive system unchanged. This notion had to be revised with the discovery that if a chemical agent disrupts the protein synthesis required for a learned fear to be reintegrated, the affective component of the fear memory can be neutralized “without changing the actual recollection of the threatening event” (Kindt, 2018, p. 2). Of particular relevance for psychotherapy was the subsequent discovery that if an experience that vividly contradicts what the old learning expects or predicts occurs shortly after the old learning was accessed, the old learning may be revised to accommodate the new information before being reintegrated (Pedreira, Pérez-Cuesta, & Maldonado, 2004).

**Memory reconsolidation.** This process—by which the neural pathways that underlie outdated learnings can be transformed, or completely eliminated and replaced—is called “memory reconsolidation” (Ecker, 2018; Nader, Schafe, & LeDoux, 2000). While the subtleties of memory reconsolidation are still being explored (Kindt, 2018), the neural mechanisms appear to be critical for “understanding how memories are formed, stored, retrieved, modified, updated and used” (Alberini & LeDoux, 2013, p. 746). Memory reconsolidation has also been shown to be more durable than extinction training (Schiller et al., 2010). Extinction does not actually eradicate the old learning. Rather, extinction overwrites the old learning with a neurologically distinct new learning that competes with the old one (thus the term “inhibitory learning” to explain the essential mechanism of extinction). As a result, the symptoms that were extinguished are subject to return (Schiller et al., 2010). Memory reconsolidation, on the other hand, transforms or completely “depotentiates” (eradicates at the synaptic level) the neural pathways supporting outdated learnings (Ecker, Ticic, & Hulley, 2012). A way of distinguishing between extinction and memory reconsolidation is that extinction is characterized by a general fear-dampening effect while memory reconsolidation results in abrupt changes in fear behavior (Kindt, 2018).

For memory reconsolidation to occur in a psychotherapy context, a vivid experience that contradicts the old learning must be generated during a brief period following the memory retrieval, called the “reconsolidation window” (Ecker et al., 2012, p. 18). This unlocks the related synapses so it becomes possible for the retrieved memory to be reintegrated into the cognitive system (reconsolidated) in a manner that updates or replaces the old learning. The content of the memory does not necessarily change after memory reconsolidation, but the memory may no longer trigger bodily reactions, emotions, interpretive frameworks, or behavioral strategies that had been associated with it. A person will be able, for instance, to recall a traumatic event, and while it will still likely be an unpleasant memory, the original sensations, emotions, or impulses to act will not be evoked.

Ecker et al. (2012) go so far as to propose that regardless of the form of psychotherapy being applied, its effectiveness with deeply rooted symptoms depends on the therapist creating the sequence of experiences that result in memory reconsolidation. While new learning of any kind, of course, creates fresh neural connections, “it is only when new learning also unwires old learning” that “major, longstanding symptoms can cease [because] their very basis no longer exists” (p. 4). The primary ways memory reconsolidation is facilitated in psychotherapy (whether through the therapist’s insight, intuition, or a clinical framework that expedites the process) are by (a) activating a contradictory experience from the client’s past that had not been accessed, (b)
creating or highlighting a situation within the therapeutic relationship that contradicts the old learning, (c) vividly accessing more recent experiences that contradict the old learning, or (d) facilitating new experiences that are inconsistent with the old learning.

**How energy psychology protocols facilitate memory reconsolidation.** Energy psychology protocols may show their greatest strength in their facility for readily generating experiences that disconfirm earlier learnings (Feinstein, 2012, 2015). Because stimulating selected acupoints can almost instantly reduce limbic arousal, the expected feelings do not occur. A traumatic memory or trigger that produced a physiological threat response is vividly imagined, but after a few rounds of acupoint tapping, the disturbing physiological and emotional responses that were expected are not experienced. The memory or trigger created a visceral expectation that an intense negatively charged emotional reaction would be evoked, but this does not happen because the acupoint stimulation deactivated the limbic system arousal. This is the necessary ingredient for the reconsolidation process. The scene that was mentally activated is reintegrated into the cognitive system in a manner that incorporates the new, unexpected experience, untethered from feelings, beliefs, and strategies that are inconsistent with the new experience.

**Case illustration.** For example, using a hypothetical situation to keep the focus on the pertinent treatment steps, a woman who had been frequently and severely criticized by her father developed a cognitive framework that includes: an unconscious core belief that she is unworthy along with an interpersonal strategy that requires her to do things so meticulously that they are beyond criticism; a perceptual filter that scans for any hint of criticism; a propensity for such criticism to evoke the same feelings of shame and being unlovable that she felt in the face of her father’s criticism; and an impulse, as an adult, to react to new criticism with strong counterattacks. Because deep emotional learnings are generalizations—perceptual filters, patterns of assessment, and propensities for action based on one or more experiences—a direct way of altering an outdated learning is by focusing on memories that reflect or were instrumental in forming the learning. After assessing the woman’s presenting complaints, associated emotional and behavioral patterns, and relevant history, the first round of tapping might be done while she brings to mind an incident in which her father’s admonishments were particularly severe. She would be asked to evoke the memory, focus on the most upsetting moment, and give it a 0-to-10 SUD (subjective units of distress) rating. This would be followed by a brief sequence designed to help her accept her feelings about the incident and address any self-judgment regarding her overwhelming response to it, then the first round of tapping, in which she might repeat a brief reminder phrase (such as “Daddy yelled at me in front of my whole class”) as she taps on a sequence of about a dozen acupoints for several seconds each.

Another SUD rating might be taken after one or several rounds of tapping. If the intensity of subjective distress has decreased but is not yet down to 0, another round of tapping might be initiated using the same or similar wording. If the SUD rating has not decreased, the woman might be asked to describe her thoughts and feelings as she brings the incident to mind. The therapist would listen for aspects of her experience or for cognitions that warrant special focus, such as her humiliation, her sense of unworthiness, her belief that everyone is poised to criticize her, the sadness she feels behind her eyes, the queasiness in her stomach. By persistently tracking and tapping on every aspect of the incident that emerges into her awareness until each can be rated at 0, the entire memory may be neutralized in the sense that she will be able to activate it
with no emotional upset or self-defeating thoughts. This is a “juxtaposition” moment (after Ecker et al., 2012), an experience that contradicts what her old learning predicts. It is the ingredient that allows the old learning to be reconsolidated in a new way. At this point, another early incident might be addressed, using the same basic protocol, and another, and so on. Eventually, a “generalization effect” takes hold so that similar incidents no longer evoke similar responses. When related early experiences are no longer initiating emotional arousal, the cognitive framework has changed substantially, and a more recent experience or an imagined experience in which the old learning would have triggered her into shame or anger, might be identified, with additional tapping applied as needed.

Because (according to Hypothesis 1) acupoint tapping sends almost instantaneous regulating signals to areas of the brain aroused by the memory, the imaginal exposure that initially generated threat or distress no longer provokes the elevated response. Because the imaginal exposure no longer provokes the expected response, the old learning (according to Hypothesis 2) is disrupted due to the physiological and emotional responses being different from what the old learning predicted. This results in the memory and the associated responses being reconsolidated with the maladaptive learnings (e.g., unwarranted fear, anger, self-doubt) having been stripped away. Because a round of tapping takes only a couple of minutes, multiple scenes and their numerous aspects may be neutralized in a single session. Conveniently, neither the energy psychology practitioner nor the client need focus on or even be aware that a “contradictory experience” must be generated if reconsolidation is to occur. The creation of the juxtaposition experience is, as illustrated in the case, inherent in the acupoint tapping protocol itself.

**Contrasts between exposure treatment and acupoint tapping protocols.** Similarities between graduated exposure and acupoint tapping protocols include that, in both, a problem-generating trigger is evoked and an intervention is introduced that changes the person’s response to the trigger by contradicting what the brain expects or predicts when the trigger is present. In exposure therapy for treating the fear of flying, for instance, the client might first be shown a photo of an airplane. Despite any anxiety that may arise, the instructions are to stay with the experience. Simultaneous diaphragmatic breathing, mindfulness, or other relaxation techniques may be introduced. The brain had associated an aversive external consequence with the trigger, and when nothing harmful occurs as the body relaxes, the threat response gradually diminishes. Another scene is selected that includes a measured increase in the arousal value of the trigger, such as imagining boarding a plane. The same procedure is applied, and scenes whose evocative power gradually increases are presented, up to in vivo experiences, until each element of flying can be tolerated. With acupoint tapping, the initial scene might be more aversive, such as recalling a panic response on a recent flight. But the memory is paired with acupoint tapping, which quickly reduces the limbic system activation. While in exposure treatment the expectation of an external event (such as something bad happening) is contradicted, with acupoint tapping protocols, the expectation of an internal event (e.g., panic or rage) is contradicted. The fear that was experienced in the earlier event, and that was briefly reexperienced when the event was recalled, is no longer experienced in the presence of the memory after the tapping has been applied. The juxtaposition experience that leads to memory reconsolidation has occurred. This produces shifts that are more rapid and durable than those generated by graduated exposure.
Other Mechanisms

Other causal mechanisms for acupoint tapping have also been proposed. Ruden (2005, 2010) has incorporated brain imaging and related neurological findings into a sophisticated biochemical model of the actions of acupoint tapping and other forms of psychosensory stimulation. Schwarz (2018) has suggested that acupoint tapping mediates the vagal system, restoring a sense of safety in traumatized individuals. Harper (2012) and Carletto, Borsato, and Pagani (2017) have reported that repetitive sensory stimulation can generate large increases in the amplitude of delta waves in areas of the brain involved in fear memories, as detected by EEG readings. After several minutes of stimulation, these amplified delta waves disrupted activated memory networks, reminiscent of the “natural memory editing system” found in delta-wave sleep (Harper, 2012, p. 61). Specifically, glutamate receptors on synapses that mediate a fear memory may be “depotentiated by these powerful waves of neuronal firing” (p. 61). When the neural circuits in the amygdala that maintain the threat response are deactivated in this manner (during virtually any exposure therapy protocol that also employs repetitive stimulation on upper parts of the body, such as acupoint tapping, according to Harper’s findings), “the material basis of the fear memory has been removed” (p. 64).

While further research is needed to evaluate these formulations, the two mechanisms postulated above—the roles of acupoint tapping in the rapid modulation of activity in targeted brain areas and in facilitating durable changes in outmoded learnings—are core processes that interact in a reciprocal manner and are consistent with existing clinical and neurological evidence.

Discussion

This assessment has presented the primary tenets of energy psychology, salient criticisms of the approach, and research-based responses to those criticisms. Three challenges in pursuing these aims have involved (a) providing a concise yet trustworthy review of the efficacy literature, (b) formulating a coherent explanation of the mechanisms by which the counterintuitive observation that tapping on the skin seems to play an instrumental role in bringing about positive clinical outcomes, and (c) a balanced presentation given the undeniable bias resulting from the author’s identification with the approach, as highlighted in the disclosure statement accompanying the paper.

Efficacy. With more than 100 clinical trials, a comprehensive review of existing research would rightfully adhere to formal guidelines such as the PRISMA criteria for reporting systematic reviews and meta-analyses (Liberati et al., 2009). Given space limitations and the broader objectives of this review, adequately addressing each point in the PRISMA checklist was not feasible. However, the assessment of research pertinent to the efficacy and speed of energy psychology protocols was informed by PRISMA’s most essential principles concerning transparency in relation to the review’s objectives, study selection and appraisalal methods, measures taken to address publication bias, client safety, and the conclusions reached.

Mechanisms of action. The two hypothesized neurological processes by which energy psychology protocols bring about rapid and lasting clinical change are built upon existing
empirical knowledge, but they have not been tested as such. While two recent brain imaging studies of acupoint tapping treatments (Di Rienzo et al., 2018; Stapleton et al., 2018) have produced findings that are consistent with these hypotheses, additional imaging studies are needed. In addition, attempts to apply the use of chemical agents that disrupt the protein synthesis necessary for memory restabilization in treating PTSD, which would lend laboratory support to the second hypothesis, have produced encouraging but still mixed results (Kindt & van Emmerik, 2016).

First-person reflection on author bias. I have provided clinical services as a licensed psychologist since the early 1970s. In 2001, I began to integrate energy psychology protocols into my practice. Based upon my subjective but compelling sense that the techniques were markedly decreasing the treatment time required to achieve desired outcomes, I became an advocate of the approach—prior to the point that research support began (to my great relief) to emerge. To counter the bias that is inevitably involved in such a shift of clinical perspective, I have endeavored in this paper to describe the most salient criticisms of the method and to address each with a balanced, evidence-based account. While the paper’s assertions are rooted in an insider’s view and should be read with due caution, they are offered in a manner that provides enough information to allow scrutiny by interested clinicians while also pointing to areas where further research is needed.

Conclusion

Energy psychology is a controversial modality that integrates contemporary clinical methods with concepts and techniques derived from ancient healing systems, particularly acupuncture and acupressure. While claims of rapid benefits with a range of conditions were widely publicized before any research backing had been presented, the past decade has seen a surge of efficacy studies that show strong outcomes. These studies constitute a modest but growing body of evidence that is supportive of the approach. Two testable hypotheses for explaining the brain mechanisms that might produce strong clinical outcomes, based on current neurological understanding, were presented. Potential advantages of integrating the stimulation of acupoints within more conventional treatment approaches, based on existing evidence, include enhanced speed and a facility for efficiently modifying learnings that are no longer adaptive.
References


