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Controversies in Energy Psychology

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Abstract

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

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Canst though not minister to a mind diseased,
Pluck from the memory a rooted sorrow,
Raze out the written troubles of the brain,
And with some sweet oblivious antidote,
Cleanse the stuff'd bosom of that perilous stuff
Which weighs upon the heart?

—Shakespeare, *Macbeth,* Act 5, Scene 3

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

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

Nonetheless, most psychologists do not view EP as a viable treatment option (Norcross, Koocher, & Garofalo, 2006). Even though empirical evidence for EP is accumulating and has arguably already reached the threshold for what the Society of Clinical Psychology (Division 12

of the American Psychological Association) considers a "probably efficacious treatment" for specified conditions (Feinstein, 2008a), its efficacy has not yet been firmly established scientifically. The approach has, in fact, been denigrated in prestigious clinical journals as resembling a pseudoscience whose proponents have presented no more than "a disjointed series of unsubstantiated assertions, ill-defined neologisms, and far-fetched case reports that blur boundaries between farce and expository prose" (Kline, 2001, p. 1188). EP and related approaches have even been characterized as "possible threats to the science of psychology and psychiatry" (Devilly, 2005, p. 437). In 1999, the American Psychological Association took the unprecedented step of censuring the approach, notifying its CE sponsors by a memo that they risked losing their sponsorship status if they offered APA CE credit for courses in the earliest established form of EP, Thought Field Therapy (Murray, 1999), and this restriction has now been generalized to all forms of EP.

In addressing the controversies surrounding EP, we will begin with reasons the approach has become such a strong area of contention within the mental health profession. The bulk of the paper, however, will focus on controversies among EP practitioners, such as (a) the field's most viable explanatory models, (b) its most effective protocols, (c) how the approach interfaces with other forms of clinical practice, (d) conditions it can treat, (e) what should be done when the method does not seem to work, and (f) how the professional community should respond to the large number of practitioners who do not have mental health credentials.

Acceptance within the Mental Health Field

Like most biological mutations, the vast majority of clinical innovations do not bring benefits that result in their ultimately being passed along to future generations. Practitioners are wise to be skeptical of enthusiastic claims and aggressively promulgated therapies. Nonetheless, just as some mutations do benefit a species, some clinical innovations move a field forward. Systemic resistance to innovation serves to keep conventional procedures neatly ordered while inhibiting progress (Kuhn, 1996). The medical field, for instance, has an embarrassing history that extends from ridiculing the notion that physicians should wash their hands before performing surgery to ignoring a known cure for scurvy as thousands of sailors died. To briefly characterize the situation with EP, enthusiasts for the approach believe it to be the psychotherapeutic equivalent of penicillin while its detractors believe it to be pseudoscience with no more new active ingredients than sugar water.

As my own initial resistance gave way, I was guardedly impressed by the results I witnessed watching EP demonstrations and hearing about treatment outcomes. I was also intellectually flummoxed by the wide range of approaches and explanations being proposed. To try to make some sense of the strange mix, I gathered a team 27 of the field's most well-known pioneers and leaders—proponents of a divergent range of EP approaches—and posed a challenge: "Can we develop a professional training program that represents a consensus regarding the methods and principles an experienced clinician new to EP should master before introducing EP into his or her clinical practice." This resulted in the book/CD-ROM training

program *Energy Psychology Interactive* (Feinstein, 2004). I learned a great deal in the process. Asking the team to speculate on causes for the slow acceptance of EP, the reasons given by these key players ranged from reliance on concepts that cannot be measured, such as "subtle energies" and "thought fields," to the lack of empirical research, to uncertainty about the mechanisms of action, to the inherent paradigm clash between ancient healing systems and conventional psychological explanations for therapeutic change. A more fundamental credibility problem, however, was also frequently mentioned in those discussions. And that is *cognitive dissonance*. There is nothing in the training or background of most clinicians or researchers that prepares them to understand how tapping on the skin can help overcome severe psychological disorders, no less to account for the speed and power with which positive clinical results are being reported.

In fact, every therapist I have interviewed who has adopted EP reports some version of the following trajectory in coming to accept EP as a viable treatment approach: (a) disbelief upon hearing it described, (b) cognitive dissonance upon seeing it performed, (c) puzzlement mixed with relief and appreciation as the method helped resolve a tricky personal issue, (d) tentative application with others, leading to surprisingly favorable outcomes, (e) frequent and confident application in clinical situations with, nonetheless, (f) a consistent sense of inner surprise that might be expressed as, "Wow, it worked again!" This journey from doubter to believer causes suspicion in colleagues looking on yet cements the certainty of the practitioner. Therapists who have moved through these stages represent a broad spectrum of professional orientations and backgrounds. They tend to describe the approach with enthusiasm, but practitioner exuberance is not known to be reliable evidence of efficacy.

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

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

It could, however, be another decade before such questions have been adequately addressed by rigorous empirical investigation. Clinical practice always runs ahead of research

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

Explanatory Models

Numerous theories have been proposed to explain the mechanisms involved in successful EP treatments, ranging from purely neurological models involving the chemistry of the brain (e.g., Ruden, in press) to those relying on subtle energies and thought fields that cannot be measured (e.g., Callahan & Callahan, 1996). Simply using the term "energy" within "energy psychology" has been scientifically confusing and an unwitting public relations disaster within the mental health profession. Difficulties with the term "energy" do not, however, necessarily reflect conceptual shortcomings within EP but instead, perhaps, that established health and mental health paradigms cannot easily assimilate so revolutionary a concept as invisible energy fields having an effect on mental and physical health. Conventional health care frameworks have remained decidedly Newtonian (Lipton, 2005) despite the past century's quantum revolution in physics where the fundamental role of energy in nature is becoming as familiar as $E = mc2$. In short, the notion that invisible energies and "fields of information" organize mental health processes (McTaggart, 2003), as well as matter, is a concept whose time has come.

Basic "energy" concepts have, in fact, been finding their way into medicine and mental health care since Willem Einthoven's Nobel prize-winning detection of the heart's energy field in 1907 and Hans Berger's measurements of the brain's energy field in 1924 (Church, 2009a). The widespread use of EEG (electroencephalography), EKG (electrocardiography), and MEG (magnetoencephalography) technology, and the promising outcomes of methods such as transcranial direct current stimulation with depressed patients (Nitsche, Boggio, Fregni, & Pascual-Leone, 2009), have made the roles of electrical impulses, electromagnetic fields, and other energies within the body that are involved in health and mental health undeniable. "Subtle" energies which cannot be detected or measured by standardized instrumentation—as described in

acupuncture theory, other healing traditions, and a number of Western lines of investigation (see Oschman, 2000)—have not, however, been as well accepted.

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

This formulation accounts for the actions of EP in the strong outcomes being reported following treatments for anxiety disorders such as PTSD, but it is too limited to explain other reported outcomes such as improved sports performance or the alleviation of physical pain. In a more expansive but still mechanical explanation for the actions of EP, Feinstein and Church (2009) have shown how EP interventions may allow targeted changes in gene expression that in themselves lead to improved psychological functioning. These models are speculative but lend themselves to empirical investigation.

Some clinical reports, however, seem to require explanatory frameworks that simply cannot be reduced to conventional terms. On the outer edge of these anecdotal accounts are claims of "non-local" beneficial effects of tapping on one's own acupoints with the intention of benefiting another individual (several dozen such accounts may be found by putting "surrogate tapping" into the search engine at http://emofree.com), analogous perhaps to the actions of other "outside-the-paradigm" phenomena such as remote healing (see Dossey, 2008) or what Radin (2006) refers to as "entanglement." Although such reports give an aura of voodoo to the field and certainly do not need to be accepted to understand the essence of EP's contribution, anomalies in science expand the paradigm (Kuhn, 1996). If such effects can be empirically demonstrated, they need to be addressed by the field's explanatory models.

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

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

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

1. Variations in the order, number, and selection of acupoints may not affect outcomes. Pignotti (2005) had 33 subjects tap a set of acupoints according to Thought Field Therapy (TFT) protocols that were keyed to the presenting problem and another 33 subjects tap acupoints randomly selected from those used in TFT and applied in a random sequence. Both groups showed equal pre- to post-treatment improvement, with an extraordinary 97% of the participants in each group reporting elimination of subjective emotional distress about the presenting problem after a single session, suggesting that the specific points and the order in which they are tapped is less important than suggested by the TFT protocols. Joaquín Andrade, a physician trained in both TFT and medical acupuncture, supervised a series of in-house exploratory investigations of imaginal exposure/acupoint tapping with staff he had trained at 11 clinics in Uruguay and Argentina (reported in Andrade and Feinstein, 2004). Andrade found that 43 of 60 phobic patients showed improvement after a single session using one tapping protocol while a statistically equivalent 46 of another group of 60 phobic patients showed improvement using the same protocol but with the points tapped in a different order. In a related set of pilot studies, Andrade found that varying the number of points that were stimulated, the specific points, and the inclusion of standard auxiliary EP interventions generally did not result in significant differences.

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

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

Waite and Holder (2003), using a modified EFT protocol for self-reported fear of heights, found that it did not matter whether the standard EFT points, random points on the arm, or points on the middle and index fingers that are stimulated while tapping on a doll were used. All three tapping conditions resulted in significant reductions in the self-reported fear of heights ($p < .003$, .001, and .001, respectively) after a single brief round of the procedure. This fear was not reduced in a no-tapping placebo group ($p = .255$), leading the investigators to conclude that acupoint tapping was not the active ingredient in the observed improvements. In a review of these findings, however, Baker, Carrington, and Putilin (2009) pointed out that the Waite and Holder study actually put EFT to an extremely "stringent test by posing the question: does very brief and atypical participant exposure to EFT (as compared to the much longer sessions routinely used in clinical practice) show any effects?" (p. 39). Based on Waite and Holder's data, they commented that a single round of a few minutes of EFT produced "significant decreases in

fear . . . We know of no laboratory controlled study in the literature using a traditional psychotherapeutic modality that has produced such a rapid statistically significant effect" (p. 42). They point out a number of reasons the investigators may have missed these implications of their findings. For instance, the investigators did not take into account the possibility that acupoints on the arm or that the fingers used for tapping the doll were being stimulated in the "no acupoint" conditions (e.g., tapping on the forefinger stimulates "Large Intestine 1," an acupuncture point that is sometimes used in the treatment of "mental restlessness," Ross, 1995, p. 306; another important acupuncture point, Pericardium 9, is located at the tip of the middle finger). The findings of the Waite and Holder study and the migraine study suggest, nonetheless, that tapping any points on the skin may have some therapeutic value.

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

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

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

The Interface of Energy Psychology and Other Clinical Approaches

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

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

Conditions for Which EP is Most Likely to Be Effective

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

The impressions about EP outcomes with anxiety, panic attacks, phobias, and improved mood are consistent with two other surveys of EP practitioners, one originating in North America, the other in South America (described in Feinstein, 2008a). In the North America survey, eighteen clinicians who were identified as leaders in EP within the United States and

Canada (based on criteria that included publications on the topic, teaching positions in established EP training programs, and visibility at national and international EP conferences), and who are also trained in conventional therapies, offered their impressions of the diagnostic categories where EP was more effective, about as effective, or less effective than the other modalities available to them. The survey used a subset of the diagnostic categories specified in an earlier report of therapist impressions at 11 clinics in Argentina and Uruguay that had adopted EP (Andrade & Feinstein, 2004), and it produced parallel findings.

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

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

Another finding of interest, mentioned in a few informal interviews I conducted as follow-up to the survey, was that practitioners trained first in EMDR and then in EP reported that EP both provides greater flexibility in the range of issues that can be addressed and that its methods can be more readily modulated by the practitioner to prevent retraumatization, an issue

that has been of concern with EMDR treatments (Hartung & Galvin, 2003). A question about using tapping methods with individuals who have convulsive disorders was mentioned by one respondent, although no instances of harm were described. While these reports of conditions where EP is effective originate from therapists who are professionally identified with and favorable toward EP and are only initial impressions, they do identify conditions and populations for which applications of EP might be more systematically investigated.

When Basic EP Protocols Don't Work

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

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

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

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

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

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

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

Practitioners Who Do Not Have Training in the Mental Health Field

A variety of personal development approaches that are independent of formal psychotherapy use EP protocols. Business executives are "coached" on how to overcome obstacles to success. Athletes are shown how to optimize their confidence and performance on the field. Physicians and other health care practitioners, recognizing the role of psychological factors in illness, are incorporating EP techniques to address their patients' anxieties, possible emotional obstacles to healing, and to enhance immune function. Even parents with minimal training in EP may teach their children to use EP to calm fears after a nightmare or reduce anxieties about going to school. Should practitioners providing such services be required to have mental health training, degrees, or licensure? Here the EP field is deeply divided.

With nearly half a million people actively subscribing to the *EFT Insights* e-letter, the vast majority of them presumably being lay practitioners, and more than thirty other EP modalities or organizations in existence, EP is a popular movement that prizes self-empowerment and views EP as a potent means for promoting it. On the other hand, seasoned

therapists who have incorporated EP, and the clinical community in general, are concerned that lay practitioners may find themselves working with conditions that are far beyond their competence, leading to no gain, possible harm, and preventing or delaying people from receiving needed help. Some of the EP practitioners who completed the surveys summarized earlier reported being consulted by people with psychiatric disorders that had been exasperated by practitioners without adequate sophistication about mental health issues. A guideline within the EP community has been to distinguish between (a) "personal coaching," where the diagnosis or treatment of psychiatric disorders is not (according to the field's guidelines) attempted, and (b) psychotherapy, where the treatment of psychiatric disorders *is* the service being offered. Only licensed mental health practitioners are legally or ethically sanctioned to provide the latter.

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

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

Concerns about client safety are, nonetheless, highly pertinent, and cautions about working with serious *DSM* disorders are emphasized even by Craig (2008), one of the most enthusiastic proponents for the popular use of the method. By distancing itself from EP, however, the professional community has missed an opportunity to participate in establishing foundational

guidelines for the popular application of the method. Yet it still has much to offer for teaching lay practitioners basic counseling and crisis intervention skills, the fundamentals of psychological development, and established principles for recognizing mental health conditions where referrals are appropriate.

Conclusion

Energy psychology has become a lightening rod for controversy within the mental health field. From its use of the term "energy" to its claims of unprecedented speed and effectiveness, it has pushed conventional paradigms and frameworks in ways that some consider profound breakthroughs and others consider breakdowns of reason and common sense. Although early research findings are promising, rigorous investigation of efficacy and active ingredients is yet to produce definitive evidence on either topic. Questions of who is helped, why they are helped, the formats and protocols that yield the best results, and who is qualified to administer them are still being debated among practitioners, further arousing suspicion in the clinical community. Yet because the approach is so easily administered and reports of its effectiveness are so dramatic and widespread, its dispersion is not within the control of the mental health field. This has created a unique and challenging situation. The mental health community has not stepped up to bring meaningful leadership by teaching applicable psychological principles to lay practitioners, about whom it is ambivalent at best. Meanwhile, blanket institutional dismissal of the approach gives the public the impression that the professional community is shamelessly protecting its turf. Yet as the method continues to spread and as those professionals who do adapt it continue to report striking outcomes, a new era in the democratization of psychotherapy may be unfolding.

References

Ahn, A.C., Wu, J., Badger, G. J., Hammerschlag, R., & Langevin, H. M. (2005). Electrical impedance along connective tissue planes associated with acupuncture meridians. *Complementary and Alternative Medicine, 5*, 10.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Andrade, J., & Feinstein, D. (2004). Energy psychology: Theory, indications, evidence. In D. Feinstein, *Energy psychology interactive* (Appendix, pp. 199 – 214). Ashland, OR: Innersource.

Baker, A. H., Carrington, P., & Putilin, D. (2009). Theoretical and methodological problems in research on Emotional Freedom Techniques (EFT) and other meridian based therapies. *Psychology Journal*, *6*(2), 34-46.

Barker, R., Kober, A., Hoerauf, K., Latzke, D., Adel, S., Kain, Z. N., & Wang, S.M. (2006). Out-of-hospital auricular acupressure in elder patients with hip fracture: A randomized double-blinded trial. *Academic Emergency Medicine, 13* 19-23.

Barlow, D. H., Allen, L. B., & Choate, M. L. (2004). Toward a unified treatment for emotional disorders. *Behavior Therapy*, 35, 205−230.

Bryant, R. A., Felmingham, K., Kemp, A., Das, P., Hughes, G., Pedutoa, A., et al. (2008). Amygdala and ventral anterior cingulate activation predicts treatment response to cognitive behaviour therapy for post-traumatic stress disorder. *Psychological Medicine, 38,* 555-561.

Callahan, R. J., & Callahan, J. (1996). *Thought Field Therapy (TFT) and trauma: Treatment and theory.* Indian Wells, CA: Thought Field Therapy Training Center.

Church, D. (2009a). *The genie in your genes: epigenetic medicine and the new biology of intention* (2nd ed.). Santa Rosa, CA: Elite.

Church, D. (2009b). The treatment of combat trauma in veterans using EFT (Emotional Freedom Techniques): A pilot protocol. *Traumatology,15*(4), XX-XX.

Church, D., Geronilla, L., & Dinter, I. (2009). Psychological symptom change in veterans after six sessions of Emotional Freedom Techniques (EFT): An observational study. [Electronic journal article]. *International Journal of Healing and Caring, 9*(1). Retrieved April 5, 2009, from http://www.patclass.com/Marshall%20Published.pdf

Church, D., Hawk, C., Brooks, A., Toukolehto, O., Wren, M., Dinter, I., & Stein, P. (2009, September). Psychological trauma in veterans using EFT (Emotional Freedom Techniques): A randomized controlled trial. Paper presented at the American Academy of Anti-Aging Medicine Conference, San Jose, Sept 9, 2009.

Church, D., Piña, O., & Reategui, C. (2009, October). Single session reduction of the intensity of traumatic memories in abused adolescents: A randomized controlled trial. Paper presented at the Eleventh Annual Toronto Energy Psychology Conference, October 15 - 19, 2009.

Craig, G. (2008). *The EFT manual.* Fulton, CA: Energy Psychology Press.

Devilly, G. J. (2005). Power therapies and possible threats to the science of psychology and psychiatry. *Australian and New Zealand Journal of Psychiatry, 39*, 437-445.

Dhond, R. P., Kettner, N., & Napadow, V. (2007). Neuroimaging acupuncture effects in the human brain. *Journal of Alternative and Complementary Medicine. 13,* 603-616.

Diener, H. (2006). Efficacy of acupuncture for the prophylaxis of migraine: A multicentre randomised controlled clinical trial. *Lancet Neurology, 5*, 310-316.

Diepold, J. H., Britt, V., Bender, S. S. (2004). Evolving Thought Field Therapy: The clinician's handbook of diagnoses, treatment, and theory. New York: W. W. Norton.

Dossey, L. (2008). Healing research: What we know and don't know. *Explore, 4,* 341 – 352.

Eden, D. (2008). *Energy medicine* (2nd ed.). New York: Tarcher/Putnam.

Ernst, E. (2006). Acupuncture—A critical analysis. *Journal of Internal Medicine*, *259*, 125-37.

Feinstein, D. (2004). *Energy psychology interactive: Rapid interventions for lasting change.* Ashland, OR: Innersource.

Feinstein, D. (2008a). Energy psychology: A review of the preliminary evidence. *Psychotherapy: Research, Practice, Training*, *45*, 199-213.

Feinstein, D. (2008b). Energy psychology in disaster relief. *Traumatology, 14*, 124–137.

Feinstein, D. (2009). Rapid treatment of PTSD: Why psychological exposure with acupoint tapping is effective. Paper submitted for publication.

Feinstein, D., & Church, D. (2009). Modulating gene expression through psychotherapy: The contribution of non-invasive somatic interventions. Paper submitted for publication.

Feinstein, D., & Eden, D. (in press). *Ethics handbook for energy healing practitioners: A guide for the professional practice of energy medicine and energy psychology.* Fulton, CA: Energy Psychology Press.

Feinstein, D., Eden, D., & Craig, G. (2005). *The promise of energy psychology: Revolutionary tools for dramatic personal change*. New York: Tarcher/Penguin.

Fleming, T. (2007). *TAT Professional's Manual.* Redondo Beach, CA: TATLife.

Gallo, F. P. (2000). *Energy diagnostic and treatment methods*. New York: Norton.

Gruder, D., (2001, July). The five keys to successful energy psychology treatment. Paper presented at First European Conference on Energy Psychology, Fürigen, Switzerland. Retrieved September 26, 2009, from http://www.thenewiq.com/files/The%20Five%20Keys%20to%20Successful%20EP%20Treatment.pdf

Hartung, J., and Galvin, M. (2003). *Energy psychology and EMDR: Combining forces to optimize treatment*. New York: Norton.

Hui, K. K. S., Liu, J., Marina, O., Napadow, V., Haselgrove, C., Kwong, K. K., . . . Makris, N. (2005). The integrated response of the human cerebro-cerebellar and limbic systems to acupuncture stimulation at ST 36 as evidenced by fMRI. *NeuroImage, 27*, 479 – 496.

Kline, J. P. (2001). Heart Rate Variability does not tap putative efficacy of Thought Field Therapy. *Journal of Clinical Psychology. 57*, 1187-1192.

Kober A., Scheck, T., Greher, M., Lieba, F., Fleischhackl, R., Fleischhackl, S., et al., (2002). Pre-hospital analgesia with acupressure in victims of minor trauma: A prospective, randomized, double-blinded trial. *Anesthesia & Analgesia*, *95*, 723-727.

Kuhn, T. S. (1996). *The structure of scientific revolutions* (3rd ed.). Chicago: University of Chicago Press.

Lang, T., Hager, H., Funovits, V., Barker, R., Steinlechner, B., Hoerauf, K., & Kober, A. (2006). Prehospital analgesia with acupressure at the Baihui and Hegu points in patients with radial fractures: a prospective, randomized, double-blind trial. *American Journal of Emergency Medicine*, *8*, 887-893.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York: Guilford.

Lipton, B. H. *The biology of belief: Unleashing the power of consciousness, matter and miracles.* (2005). Santa Rosa, CA: Elite.

McTaggart, L. *The field: The quest for the secret force of the universe.* (2003). New York: HarperCollins.

Mollon, P. (2007). Thought Field Therapy and its derivatives: Rapid relief of mental health problems through tapping on the body. *Primary Care and Community Psychiatry, 12,* 123–127.

Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M.J., Young-Xu, Y, & Stevens, S. P. (2006). Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *74*, 898-207.

Murray, B. (1999). APA no longer approves CE sponsorship for Thought Field Therapy. *APA Monitor on Psychology*, *30*(11), 9.

Nitsche, M. A., Boggio, P. S., Fregni, F., & Pascual-Leone, A. (2009). Treatment of depression with transcranial direct current stimulation (tDCS): A review. *Experimental Neurology, 219,* 14-19.

Norcross, J. C., Koocher, G. P., & Garofalo, G. P. (2006). Discredited psychological treatments and tests: A Delphi poll. *Professional Psychology: Research and Practice, 37*, 515-522.

Oschman, J. (2000). *Energy medicine: The scientific basis.* New York: Harcourt.

Pariente, J., White, P., Frackowiak, R.S.J., & Lewith, G. (2005). Expectancy and belief modulate the neuronal substrates of pain treated by acupuncture. *NeuroImage, 25*, 1161-1167.

Pignotti, M. (2005). Thought Field Therapy Voice Technology vs. random meridian point sequences: A single-blind controlled experiment. *The Scientific Review of Mental Health Practice, 4*(1), 72-81.

Radin, D. (2006). Entangled minds: Extrasensory experiences in a quantum reality. New York: Paraview.

Ross, J. (1995). *Acupuncture point combinations: The key to clinical success*. Philadelphia: Churchill Livingstone.

Rubik B. (2002). The biofield hypothesis: Its biophysical basis and role in medicine. *Journal of Alternative and Complementary Medicine, 8*, 703-717.

Ruden, R. (in press). *When the past is always present: A primer on the origins, consequences, and cure of emotional traumatization.* New York: Routledge.

Sakai, C.S., Connolly, S. M., & Oas, P. (2009). Treatment of PTSD in Rwandan genocide survivors using Thought Field Therapy. Paper submitted for publication.

Schulz, K. M. (2009). Integrating energy psychology into treatment for adult survivors of childhood sexual abuse: An exploratory clinical study. *Energy Psychology: Theory, Research, and Treatment, 1*(1).

Takakura, N., & Yajima, H. (2009). Analgesic effect of acupuncture needle penetration: a double-blind crossover study. *Open Medicine, 3*(2). Retrieved September 9, 2009, from http://www.openmedicine.ca/article/view/189/235

Truzzi, M. (1976). Editorial. *The Zetetic, 1*(1), 4.

Waite, L. W., & Holder, M. D. (2003). Assessment of the emotional freedom technique: An alternative treatment for fear. *The Scientific Review of Mental Health Practice, 2* (1) 20-26.

Wang, S.-M., DeZinno, P., Lin, E.C., Lin, H., Yue, J. J., Berman, M. R., . . . & Kain, Z. V. (2007, Oct.). Auricular acupuncture as a treatment for pregnant women who have low back and posterior pelvic pain: a pilot study. Presented at the Annual Meeting of the American Society of Anesthesiologists, San Francisco, CA, Oct. 13-17, 2007.

World Health Organization. (2003). *Acupuncture: Review and analysis of reports on controlled clinical trials*. Geneva: Author.