ENERGY PSYCHOLOGY INTERVENTIONS IN DISASTER RELIEF

Additional Cases

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

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

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TREATMENT OF PTSD FOLLOWING 9-11
(with video available for inspection[1])

Reported by Mary Sise, M.S.W.

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

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

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

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

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

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

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

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CHANCE SURVIVORS OF COLD-BLOODED SLAUGHTER

Reported by Carl Johnson, Ph.D., ABPP

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

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

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

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

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

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

Sixteen months later, Kosovo's chief medical officer brought me to the village to interview both men, probably because the case had achieved international notoriety. Both men indicated that there had been no relapse, along with their willingness for their improvement to be shared with others who are in a position to help survivors. Eight months later—in June 2002, two years following the treatments–my colleague Paul Oas, Ph.D., and I visited the men and learned that the treatments for both were still holding strong.

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

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THE NAIROBI EMBASSY BOMBING

Reported by Jenny Edwards, Ph.D., TFTdx

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

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

We finally came to a woman who had mostly lower body injuries. She was lying on her bed staring into space, clearly in a great deal of pain. Her shoes had been blown off by the bombing,

and among other injuries, she had a lot of glass in her feet. Though she was on pain medication, the doctors had not been around to see her yet, and she rated her pain at a "10." Since her injuries were less severe than others, I offered to "Try something that might help." "I'll do anything," she said. "I'm in so much pain. I keep thinking a bomb will explode any minute in the hospital. I know it's probably not going to happen, but I can't get it out of my mind!"

I worked on the pain first, using the TFT pain algorithm, and her pain came down from a "10" to a "5." But then it wouldn't budge. It occurred to me we needed to tap for the trauma in order for the pain to go any lower. She rated the trauma as a "10," and using the TFT complex trauma algorithm, it came down to a "0" immediately. After that, we tapped again for the pain, and it went down to a "0." She looked at me a little bewildered: "I've played the pictures of the bombing over and over in my mind, almost without stopping, since Friday. It's really strange. Now I'm not doing that any more. I think that I'll be able to sleep tonight."

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

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

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

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ENERGY PSYCHOLOGY WITHIN A CITY'S CRISIS RESPONSE SYSTEM

Jim McAninch was the Practitioner

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

1. To reduce emotional tension.

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

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

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

The head of Pittsburgh's CISM Team was at first highly skeptical about having McAninch utilize TFT as part of the CISM disaster response. However, enough instances have now been logged in which TFT clearly brought about rapid and striking results in facilitating the emotional recovery of survivors of events involving fatalities that McAninch has been asked to provide TFT training to the entire Pittsburg CISM Team. Three of McAninch's documented cases follow.

Industrial Crisis Response Case # 1

McAninch was called to a site where an employee of a small company had been electrocuted. A worker had instructed his co-worker to push a panel button, and the co-worker was electrocuted on the spot. The survivor and six others watching had to deal with the horrible scene and their unsuccessful attempts to save the man's life. They were all traumatized by the horrific death. The intense odor of burning flesh remained vivid in each of their memories. For two of the witnesses, the death also caused past traumas to resurface. One recalled the gruesome car crash fatalities he'd witnessed as a tow truck operator for twenty years. The worker who had instructed that the button be pushed had years earlier found his wife dead in a snow bank. In the current disaster, after the electricity was no longer passing through his co-worker's body, he had unsuccessfully tried to resuscitate the burned man, adding to his trauma and guilt. And, as a morbid reminder, he couldn't get rid of the smell or taste of the vomit that had come into his mouth during the resuscitation effort. McAninch treated him first as the group watched. Using a TFT complex trauma algorithm, he assisted the man with his anger and guilt until the distress levels were down

to “0.” McAninch then had the others get into pairs and copy the treatment on themselves and on each other, until all the trauma-related emotions were all down to “0.” A week later, when he returned to do follow-up, each of the survivors was able to recall and talk about the tragedy without experiencing retraumatization.

Industrial Crisis Response Case #2

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

Industrial Crisis Response Case #3

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

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

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

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WHEN A LOVED ONE HAS BEEN LOST

Reported by Carl Johnson, Ph.D., ABPP

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

I learned this in a refugee camp near Oslo, Norway, in May 1999, during the Kosovo war. It turned out to be an invaluable understanding during my subsequent nine trips to Kosovo as well for my work with survivors in Rwanda, the Congo, and other areas of warfare and ethnic violence. My visit to Norway took place nine months prior to my first trip to Kosovo. I treated an ethnic Albanian refugee for his grief following the war death of his mother. After some initial progress, the muscle tests weren't revealing any further weaknesses in his energy system, yet he consistently reported that his SUD, which started at 10, had come down only to 5. It never got lower than that.

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

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

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

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

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

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ALTERNATIVE TO PAIN MEDICATION

Reported by Sophia Cayer

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

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

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DEPRESSION IN THE AFTERMATH OF DISASTER

Reported by Sophia Cayer

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

I saw her at a gathering for survivors. Her friends, who had initially put me together with her, seemed amazed, reporting that she was her cheerful self again. I will always remember her smiles and hugs of gratitude.

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

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DISASTER RELIEF GROUP TREATMENT

Reported by Roseanna Ellis, L.M.T.

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

Ellis met the pastor of a local church. She thought EFT might be useful for him to know about, and she started to explain it to him. The best way to explain EFT is to demonstrate it, so she inquired about his personal situation. "Compassion fatigue" is a term used for the physical and emotional exhaustion frequently seen among those who have been helping in a disaster area. The pastor acknowledged that he was feeling extremely stressed, both from compassion fatigue and also from some longstanding personal challenges. He rated his level of stress at a 10 (of 10). Within 15 minutes, his self-reported stress level was 0. Ellis "challenged" him to *make himself* feel stressed. He couldn't. Ellis observed, "If this could make years of stress go away within minutes, imagine what it will do for the trauma of the evacuees?" He invited her team of four to come to the church's Wednesday evening "family night" to work with his congregation, which was hosting a number of hurricane victims. Of approximately 30 people in attendance, 13 were evacuees; the others were regular members of the church.

After the pastor gave a brief introduction, explaining the framework for the evening, the four practitioners each took a role in the presentation. One explained the theory of stress, one introduced EFT, another described its history, and the fourth demonstrated the tapping points. Then the practitioners worked with individuals in front of the group, one at a time. During the course of the two-hour meeting, each practitioner worked with two or three people. Because of the rapid response associated with energy interventions, each person only needed to be treated for between ten and twenty minutes.

A 52-year-old woman, for instance, who had been forced from her home, made each of the following statements, and with tears flowing, rated each as a 10 on the 10-point subjective units of distress scale:

> I feel lost.
> I feel displaced.
> I feel confused and unfocused.
> I feel angry.
> I feel all alone.

I feel I have no place in this whole world that I can call my home.
No one knows where to reach me because they keep moving us from place to place.

At the end of twenty minutes, focusing on these one at a time, she was calm, in control, and reporting that her distress level with each statement was now at 0 of 10. She stated, "I have the world to choose from for my next home . . . I have always wanted to write my life story and was afraid to, but now I am ready . . . I could have died like some of my friends, but God saved me for a purpose . . . Maybe Katrina was the end of my old life and a renewed beginning."

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

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

Before the individual work with these people, each person in the audience identified a personal area of emotional distress and rated it from 0 to 10. They then put their own issues aside as the individual work was conducted. But with each person on the stage, the audience supported that person's work by doing the same procedures the person on stage was doing. So if the person on stage was tapping a set of acupuncture points while stating, "feeling displaced," the audience was doing the exact same tapping and making the exact same statement. Known as "Borrowing Benefits," this method is repeatedly reported to bring down the distress level for the original issue identified by the audience members, even if there is no treatment that focuses specifically on their own issues. And indeed, every person in the audience at the church indicated at the end of the evening that the initial distress level they had identified had decreased when they again tuned into their original issue. According to Ellis, "It's a natural to use EFT with a group of people who have shared the same experience, especially one like Katrina. Everyone can relate to the shock, grief, anger, displacement, and fear of the unknown. Then seeing other people quickly calm themselves gives hope. And feeling your own emotions rapidly easing is the start of healing."

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

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GROUP FOCUS ON A PHYSICAL AILMENT

Reported by John Hartung, Psy.D.

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

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

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

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

While she sat quietly with her eyes closed, I asked all of the members of the course to hold the Tapas posture for several minutes while sending what they defined as love and positive intention to the woman. We repeated this for several more minutes. I then asked her to stand, walk, and tell us what she noticed. She said she had begun to feel sensation in her calf and ankle. We

continued, with her sitting as the rest of the group tapped the EFT points, again while thinking in positive ways about the woman. After several more minutes, she reported more feeling in her foot. We continued for another 10 minutes. Each new exercise was a repeat of something I had already tried with her, so the additional component, and apparently the active one, was the increased intentional energy from the group, plus the awareness of the woman that she was being treated not by one but by 20-some "therapists." She ended her session by walking, stretching, and laughing, and she seemed totally credible when she said she could feel about 90% of the sensation she was able to feel prior to the tsunami.

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

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

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

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TRAINING LOCAL MEDICAL AND SOCIAL SERVICE PERSONNEL FOLLOWING KATRINA

Reported by Herb Ayers, M.A.

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

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

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

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

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

Written evaluations were obtained from 87 of the participants. Of these, 86 stated that they experienced positive changes and/or elimination of the problems they were experiencing at the time. Data compiled by one of the practitioners, Caroline Sakai, Ph.D., on the 22 clients she treated, showed that the presenting complaints included anger, anxiety, depression, eating in order not to feel, frustration, guilt and survivor guilt, hurt, loss, loss of control, need for improved performance, overwhelm, panic, physical pain, resentment, sadness, shame, stress, traumatization, and worry. Each problem area was rated by the client on the 1 to 10 Subjective Unites of Distress scale. Before treatment, the average (mean) score for the 51 problem areas described by the 22 clients was 8.14. After treatment, in most cases consisting of a single session of under 15 minutes, it was down to 0.76. Most clients reported wanting to learn more about how to use TFT to help themselves, their patients, and their own families.

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Footnote

1. The height phobia treatment described in the text, and a 2 ½ year follow-up interview, can be viewed on a DVD entitled "Introduction to Energy Psychology," available through http://innersource.net/energy_psych/ep_introduction_dvd.htm). A video showing rapid responses during two energy psychology sessions, and a follow-up interview, with a woman suffering from PTSD symptoms after 9-11 is available through http://www.integrativepsy.com/products.asp. Another, also with follow-up, showing a striking and almost instant reduction in the symptoms of a crime victim who had been suffering for six months with PTSD that required a hospitalization is available from the same site. Dozens of other cases demonstrating rapid therapeutic responses with a range of clinical conditions have been filmed and are available on the training DVDs offered through http://emofree.com/products.htm.

CASE COLLECTION AND EDITING:

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

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