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ENERGY PSYCHOLOGY: A REVIEW OF THE PRELIMINARY EVIDENCE

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Abstract

Energy psychology utilizes imaginal and narrative-generated exposure, paired with interventions that reduce hyperarousal through acupuncture and related techniques. According to practitioners, this leads to treatment outcomes that are more rapid, powerful, and precise than the strategies used in other exposure-based treatments such as relaxation or diaphragmatic breathing. The method has been exceedingly controversial. It relies on unfamiliar procedures adapted from non-Western cultures, posits unverified mechanisms of action, and early claims of unusual speed and therapeutic power ran far ahead of initial empirical support. This paper reviews a hierarchy of evidence regarding the efficacy of energy psychology, from anecdotal reports to randomized clinical trials. Although the evidence is still preliminary, energy psychology has reached the minimum threshold for being designated as an evidence-based treatment, with one form having met the APA Division 12 criteria as a “probably efficacious treatment” for specific phobias; another for maintaining weight loss. The limited scientific evidence, combined with extensive clinical reports, suggests that energy psychology holds promise as a rapid and potent treatment for a range of psychological conditions.

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**ENERGY PSYCHOLOGY:
A REVIEW OF THE PRELIMINARY EVIDENCE**

David Feinstein, Ph.D.

Energy psychology (EP) is comprised of a set of physical and cognitive procedures designed to bring about therapeutic shifts in targeted emotions, cognitions, and behaviors (Gallo, 2004). It has been used as an independent psychotherapeutic approach, as an adjunct to other therapies, and as a back home tool for emotional self-management. In all three applications, while the method is grounded in established psychological principles regarding affect, cognition, and behavior, it also incorporates concepts and techniques from non-Western systems for healing and spiritual development. Specifically, energy psychology, which is a derivative of energy medicine (Feinstein & Eden, 2008), postulates that mental disorders and other health conditions are related to disturbances in the body's electrical energies and energy fields.

Many of the body's electrical systems and energy fields are understood, readily verified, and a focus of established interventions. The application of lasers and magnetic pulsation, for instance, can be described in terms of specific, measurable wavelengths and frequencies that have been found to be therapeutic (Oschman, 2003). Other postulated energies are considered to be of a more subtle nature and have not been directly measured by reproducible methods. While such subtle energies are generally not recognized in Western health care frameworks, they are at the root of numerous ancient systems of healing and spiritual development that are not only still in wide use throughout the world but increasingly being utilized in the West (Meyers, 2007).

EP has been referred to as "acupuncture without needles" in treating mental health disorders. The efficacy of acupuncture and acupressure (a non-needle form of acupuncture) is well established. The World Health Organization (WHO, 2002) lists 28 conditions where scientific studies strongly support acupuncture's efficacy and 63 more conditions for which therapeutic effects have been observed but not scientifically established. A review of 420 articles by Harvard Medical School's Consumer Health Information website (<http://www.intelihealth.com>) found at least preliminary evidence for the efficacy of acupressure with many of the conditions listed in the WHO report, including a variety of affect-related conditions, such as anxiety, depression, addictions, insomnia, and hypertension.

More than two dozen variations of EP can be identified, with the most well-known being Thought Field Therapy (TFT), the Tapas Acupressure Technique (TAT), and the Emotional Freedom Techniques (EFT). Many of the variations adapt practices and concepts from acupuncture and acupressure; others borrow from yoga, meditation, qigong, and other traditional practices. Some conceive of their distinctive therapeutic mechanism as the activation of electrical signals that purportedly influence brain activity (Ruden, 2007); others as catalyzing shifts in putative energy fields, such as the body's biofield (Rubik, 2002). TFT, TAT, and EFT, each utilizing techniques derived from acupuncture and acupressure, have received by far the most attention and investigation, and they will be the focus of this review.

A Shared Core Strategy

Nearly all the therapies and emotional self-management approaches that fall under the heading of EP, however, share a common core strategy. They combine physical interventions for regulating electrical signals or energy fields with mental involvement in a feeling, cognition, or behavior that is a target for change. This simultaneous pairing of the physical activity and mental activation is believed to therapeutically alter the targeted response.

In brief, beyond whatever unfamiliar methods it may incorporate, EP is an exposure-based treatment. The effectiveness of exposure therapies with PTSD and other anxiety disorders is well established. Exposure is, in fact, the single modality for which the evidence is sufficient to conclude, according to stringent scientific standards (National Institute of Medicine's Committee on Treatment of Posttraumatic Stress Disorder, 2007), that the method is an efficacious treatment for PTSD. Other treatments that have strong empirical support in treating PTSD, such as cognitive-processing therapy, stress inoculation training, and eye movement desensitization and reprocessing (EMDR), also generally incorporate substantial exposure components (Keane, Foa, Friedman, Cohen, & Newman, 2007).

In energy psychology, as with other exposure-based treatments, exposure is achieved by eliciting—through imagery, narrative, and/or in-vivo experience—hyperarousal associated with a traumatic memory or threatening situation. Unique to energy psychology is that extinction of this association is facilitated by 1) the manual stimulation of acupuncture and related points that are believed to 2) send signals to the amygdala and other brain structures that 3) quickly reduce hyperarousal. When the brain then reconsolidates the traumatic memory, the new association (to reduced hyperarousal or no hyperarousal) is retained. According to practitioners, this leads to treatment outcomes that are more rapid (less time; fewer repetitions) and more powerful (higher impact; greater reach) than the strategies used by other exposure-based treatments that are available to them, such as relaxation, desensitization, mindfulness, flooding, or repeated exposure. Another clinical strength reported by practitioners is increased precision, and thus less chance of retraumatization. By being able to quickly reduce hyperarousal to a targeted stimulus, numerous aspects or variations of a problem may be identified, precisely formulated, and treated within a single session.

A survey of several major EP textbooks (Callahan & Trubo, 2002; Diepold, Britt, & Bender, 2004; Feinstein, 2004; Gallo, 2004; Hartung & Galvin, 2003; Mollon, 2008) reveals four typical foci of EP interventions: immediate reduction of elevated affect, extinguishing conditioned responses, addressing complex psychological problems, and promoting optimal functioning or peak performance. For instance, the stimulation of specified acupuncture points (acupoints) has been shown to decrease activation signals in the amygdala (Hui, et al., 2000), and holding such points has been shown to rapidly decrease anxiety in people who sustained minor injuries during an accident (Kober, et al., 2002). Another example of EP reducing elevated affect is that individuals required to describe recent traumatic experiences to government officials evidenced less anxiety and greater accuracy in their reports when they tapped a specified set of acupoints while recounting the event (Carrington, 2005). By adding imaginal exposure, this core strategy has been shown to extinguish a range of maladaptive conditioned responses, such as specific phobias (Wells, Polglase, Andrews, Carrington, & Baker, 2003) and test-taking anxiety (Sezgin & Özcan, 2004). Elaborations upon it have been applied to a spectrum of psychological

problems and goals (Gallo, 2002). Relatively easy to learn, the method is most frequently integrated into the clinician's existing repertoire when treating complex issues.

Controversies

EP has been exceedingly controversial among psychotherapists. Its advocates have for more than two decades been claiming a level of clinical effectiveness for a range of conditions that surpasses that of established treatment modalities in its speed and power, but a robust body of research directly supporting these claims has yet to be produced. Confounding this basic credibility problem, EP is rooted in an unfamiliar paradigm adapted from non-Western health care practices, its techniques look patently strange (e.g., humming or counting while tapping on the back of one's hand), and even its most committed practitioners disagree about the mechanisms that might explain the results they report.

The approach has, nonetheless, gained a strong popular following. *EFT Insights*, an e-newsletter that provides instruction on how to utilize EFT on a professional as well as self-help basis, had 368,000 active subscribers at the time of this writing, and this number was showing a net increase of more than 7,000 per month (G. Craig, personal communication, December 27, 2007). The media has been intrigued by claims made by EP practitioners and their clients. Numerous EP phobia treatments have, for instance, been aired on television talk-shows, including dramatic pre- and post-treatment clips. In one such program, a woman who convincingly described a terror of spiders appeared calm, following a brief TFT session, as she permitted a tarantula to crawl on her hand (Coghill, 2000).

EP protocols are also increasingly being utilized in traditional health care settings such as Health Maintenance Organizations (Elder, et al., 2007), disaster relief efforts (Feinstein, 2008), and Veteran's Administration hospitals. Lynn Garland, a social worker with the Veterans' Healthcare System in Boston, for instance, reports that she, along with numerous colleagues using energy psychology in the V.A., are having "dramatic results in relieving both acute and chronic symptoms of combat-related trauma" (Feinstein, Eden, & Craig, 2005, p. 17).

An international professional organization with more than 1,000 members, the Association for Comprehensive Energy Psychology (www.energypsych.org), was incorporated in the U.S. in 1999 and has developed a comprehensive certification program and ethics code. EP is increasingly recognized in Europe, with "Advanced Energy Psychology" qualifying as continuing education for psychologists, physicians, and related professions in several countries, including Germany, Austria, and Switzerland. A review of one of EP's major texts (*Energy Psychology Interactive*; Feinstein, 2004) in the online book review journal of the American Psychological Association (APA) notes that because EP successfully "integrates ancient Eastern practices with Western psychology [it constitutes] a valuable expansion of the traditional biopsychosocial model of psychology to include the dimension of energy." The review, by a former APA division president, describes EP as "a new discipline that has been receiving attention due to its speed and effectiveness with difficult cases" (Serlin, 2005).

Professional gatekeeping organizations and forums in the U.S. have not, however, been persuaded. The APA itself singled out EP as an unacceptable topic for its sponsors to offer psychologists for continuing education credit, a policy still in effect at the time of this writing. A scathing commentary by Harvard psychologist Richard McNally (2001), in a special issue of the

Journal of Clinical Psychology focusing on TFT, argued that the methodological flaws in existing studies of the approach render their data to be uninterpretable, ultimately suggesting that until TFT founder Roger Callahan “has done his homework, psychologists are not obliged to pay any attention to TFT” (p. 1173). In one of the few standard psychology texts to mention EP, Corsini (2001), editor of an anthology of innovative psychotherapies, explains his choice to include a chapter on such an “outlandish” approach by noting that TFT “is either one of the greatest advances in psychotherapy or it is a hoax” (p. 689).

Beyond the familiar dilemma of lag time between the introduction of a new therapy and its scientific evaluation, assessing the viability of EP poses several additional challenges. Its purported actions cannot be explained by conventional clinical models and some of its methods do not appear to be based upon any rationale accepted by Western science. In addition, despite strong popular interest and a quarter century of efficacy claims by growing numbers of credible therapists, neutral investigators have not carried out comparison studies between EP and conventional modalities. While the relatively few studies that have been conducted by the field’s adherents tend to support the new approach, clinicians, insurance providers, and the public are required to make the most informed assessments possible amidst strong conflicting opinions and despite very limited scientific evidence for either establishing or refuting claims about the method’s therapeutic power.

The purpose of this paper is to consider the existing evidence that bears upon the efficacy of TFT, TAT, and EFT, the most widely used forms of EP (a review of literature, websites, and professional organizations suggests that upwards of 95% of EP treatments are provided by a practitioner trained in one of these modalities). Subsequent investigations are needed to compare these approaches with one another, but their shared strategy of stimulating acupoints while mentally activating a targeted psychological concern is the present focus. While waiting for the body of peer-reviewed, replicated, randomized controlled trials (RCTs) that would be required to scientifically confirm or disconfirm the claims of EP practitioners, this review considers the limited number of existing RCTs as well as a hierarchy of evidence that has not been peer-reviewed, such as anecdotal reports, uncontrolled investigations, master’s and doctoral studies, and other unpublished research. An unusual amount of data of this nature is available. By considering each rung of this hierarchy of evidence on its own merits and within an understanding of its limitations, an informed preliminary assessment is possible.

The Review

Anecdotal Reports, Systematic Observation, and Case Studies

An anecdotal report, in itself, carries a low level of scientific credibility. Besides not offering a comparison condition to control for placebo and other nonspecific therapeutic elements, anecdotal evidence is subject to both selection bias (negative outcomes are less commonly reported by the advocates of a method) and assessment bias (subjective and sometimes objective incentives for perceiving and reporting positive outcomes may be substantial). However, when reports coming in large numbers from a range of sources quite removed from the method’s originators are consistently corroborating one another, a different level of evidence may be accumulating. Strong anecdotal validation of EP is being offered in a

wide variety of settings by second, third, and fourth generation practitioners, as contrasted with the method's developers, who are characteristically biased in evaluating their own approach.

Anecdotal Evidence. Energy psychology maybe unprecedented in the amount of systematically-collected anecdotal outcome data it has accumulated. The primary EFT website (<http://emofree.com>), for instance, posts thousands of anecdotal reports based on self-help, peer-help, and professional applications of EFT. A search engine on the site lists, at the time of this writing, 165 entries for depression cases, 460 for anxiety, 102 for PTSD, 141 for weight loss, 128 for addictions, 90 for sports performance, and 389 for physical pain (which often has an emotional component). While the descriptive detail and quality of these entries varies considerably, most of them present at least one report of a treatment session with a successful or partially successful outcome as judged by the recipient and/or practitioner. The main TAT website (<http://www.tatlife.com>) and its newsletter archives include 93 brief practitioner reports of the successful use of TAT with a variety of presenting problems.

Treatment sessions are increasingly being recorded on video and made available for critical examination. Video tapes of sessions with diagnosable disorders, particularly when follow-up sessions are included, allow a more detailed assessment of a method than other types of anecdotal evidence. More than 200 EFT sessions are part of DVD training programs offered at <http://emofree.com>. Among these are rapid and dramatic improvements shown in six inpatients at the Veteran's Administration Hospital in Los Angeles suffering from prolonged, severe PTSD.

Systematic Observation of EP in Disaster Relief. Numerous case histories illustrating the clinical uses of EP are described in the published literature (e.g., Bray, 2006; Gallo, 2002), and as EP has been increasingly applied in disaster relief settings, a body of anecdotal and field reports has been accumulating suggesting the method is effective in some of the most challenging situations mental health practitioners can face. TFT treatments by international teams working with post-disaster victims in Kosovo, Rwanda, the Congo, and South Africa tallied the treatment outcomes with 337 individuals (Feinstein, 2008). Treatment focused on reducing severe emotional reactions evoked by specific traumatic memories, which often involved torture, rape, and witnessing loved ones being murdered. Following the EP interventions, 334 of the 337 individuals were able to bring to mind their most traumatic memories from the disaster and report no physiological/affective arousal. Twenty-two traumatized Hurricane Katrina care givers participated in a 30-minute group orientation and followed by an individual TFT session of approximately 15 minutes. They reported an average SUD (a 0 to 10 "Subjective Units of Distress" self-report scale, after Wolpe, 1958) reduction from a mean of 8.14 to 0.76 on 51 problem areas they had earlier identified (http://www.innersource.net/energy_psych/articles/ep_energy-trauma-cases.htm).

Reported improvements after post-disaster application of EP methods have frequently been corroborated by local health authorities who had no affiliation to a particular treatment approach (Feinstein, 2008). The Green Cross (The Academy of Traumatology's humanitarian assistance program), founded in 1995 after the Oklahoma City bombings to attend to the mental health needs of disaster victims, has begun to use EP as a standard protocol for working with disaster victims. According to the organization's founder, Charles Figley, who also served as the chair of the committee of the Department of Veteran Affairs that first identified PTSD: "Energy psychology is rapidly proving itself to be among the most powerful psychological interventions available to disaster relief workers for helping the survivors as well as the workers themselves" (C. Figley, personal communication, December 10, 2005).

Case Studies Using Brain Scans. Case studies are distinguished from anecdotal reports by the inclusion of objective outcome measures, and they also frequently supply greater clinical detail which creates a stronger context for interpreting findings. Several case studies have examined physiological shifts following EP treatments. A series of digitized EEG scans, for instance, examined changes in the ratios of alpha, beta, and theta frequencies distributed throughout the brain prior to TFT treatment for an individual diagnosed with generalized anxiety disorder (GAD) and after 4, 8, and 12 sessions (posted at http://innersource.net/energy_psych/epi_neuro_foundations.htm). Over the 12 sessions, the symptoms of GAD abated according to self-reports and SUD ratings. The brain wave patterns, correspondingly, normalized, as compared with profiles in databases.

A second single-case study, by Diepold and Goldstein (2000), evaluated quantitative electroencephalogram (qEEG) measures before a TFT session, immediately following the session, and on an 18-month follow-up. Statistically abnormal brain-wave patterns were observed when the subject thought about a targeted personal trauma prior to the session, but not when a neutral (baseline) event was brought to mind. Reassessment of the brain-wave patterns following a TFT treatment that focused on the traumatic memory revealed no statistical abnormalities when the trauma was again mentally activated. Subjective distress, based on self-report, was also eliminated. On 18-month follow-up, the brain wave patterns were still normal when the trauma was brought to mind. Two other brain scan studies (Lambrou, Pratt, & Chevalier, 2003; Swingle, Pulos, & Swingle, 2004), with 4 claustrophobic subjects and 9 traumatized subjects, respectively, also revealed normalized post-treatment brain wave patterns.

In brief. As a group, the anecdotal reports, field observations, and case studies give an impression of therapeutic outcomes that are both rapid and dramatic, as summarized in Table 1.

Table 1: Summary of Anecdotal Reports, Systematic Observation, and Case Studies of EP

Source	Treatment	Condition	Type of Evidence	Number Reported
http://emofree.com	EFT	Range of Problems and Goals	Anecdotal Report	2000+
			Taped Session	200+
http://www.tatlfe.com	TAT	Range of Problems and Goals	Anecdotal Report	93
			Taped Session	20
Bray, 2006	TFT	Post-Traumatic Distress	Anecdotal Report	6
http://www.innersource.net/energy_psych/articles/ep_energy-trauma-cases.htm	TFT or EFT	Post-Disaster Trauma	Anecdotal Report	8
	Group EFT		Anecdotal Report	3 groups
	TFT		Systematic Observation	22
Feinstein, 2008	TFT	Post-Disaster Trauma	Systematic Observation	337
See “Case Studies Using Brain Scans” (p. 13)	TFT or EFT	Brain Wave Abnormalities	Case Study	15

Note: EFT = Emotional Freedom Techniques; EP = Energy Psychology; PTSD = posttraumatic stress disorder; TAT = Tapas Acupressure Technique; TFT = Thought Field Therapy.

While caveats about selective reporting and the power of nonspecific therapeutic factors such as placebo must still be taken into account, this body of evidence is too large and consistent to be dismissed a priori as it provides context for evaluating longstanding claims of strong clinical benefits that are mired in controversy.

Uncontrolled Outcome Studies

Eight uncontrolled outcome studies of EP have been conducted, four of which have been published after peer-review. Uncontrolled outcome studies measure the effects of a treatment intervention with a sample of subjects according to specified outcome criteria. No attempt is made to control for placebo, suggestion, compliance, expectation, the passage of time, or other nonspecific therapeutic factors via comparison with a no-treatment group or with another therapy.

For instance, 9 veterans of the United States military who had each seen combat duty, and 2 family members, all with symptoms of PTSD, were provided two to three daily EFT sessions averaging about 60 minutes each over a five-day period. Pre-/post-measures included the Symptom Assessment 45 (SA-45), the Posttraumatic Stress Disorder Checklist—Military (PCL-M), and a sleep diary. The SA-45 and the PCL-M were administered 30 days prior to treatment, immediately prior to treatment, immediately after treatment, and 30 days after treatment. Scores 30 days prior to treatment and immediately prior to treatment showed no

statistically significant changes on any of the measures. Immediately following treatment, the scores for PTSD had dropped by 63%, for depression by 25%, and for anxiety by 31%, and each had fallen into the range of a normal population. Self-reported insomnia also decreased. Scores were still within normal ranges on 30-day post-testing (Church, 2008). With estimates that the number of U.S. troops needing treatment for PTSD or major depression exceeds 300,000 (Tanielian & Jaycox, 2008), the relatively short treatment time and the striking outcomes reported in this pilot study warrant notice.

Use of TFT at the El Shadai orphanage in Rwanda also resulted in rapid improvement with longstanding symptoms of PTSD, as indicated by standardized instruments. Many of the children had seen parents, relatives, or neighbors die by machete during the ethnic cleansing twelve years earlier or were reliving the horrors of the massacre of 800,000 Rwandans. Daily flashbacks and nightmares were common, as were bedwetting, depression, withdrawal, isolation, difficulty concentrating, jumpiness, and aggression. Standardized pre- and post-treatment tests for PTSD (translated into Kinyarwanda) were administered to 50 of these children (27 boys and 23 girls), ages 13 through 18, and a children's PTSD assessment tool for parents and guardians was administered to their caregivers. Treatment, provided in April and May 2006, generally involved three TFT sessions of approximately 20 minutes each. The tests were structured after DSM IV criteria for PTSD. Average symptom scores, based on both the tests taken by the children and the caregivers' observations about the children, substantially exceeded the cutoffs for a diagnosis of PTSD. Scores after the three sessions were substantially lower than the cutoffs. Immediate reductions in flashbacks, nightmares, and other symptoms were common. Retesting a year later showed that the improvements held. Details of these findings are being prepared for publication (C. Sakai, personal communication, March 7, 2008).

Table 2: Six Uncontrolled Outcome Studies

Source *= <i>peer-reviewed</i>	Treatment	Condition, N	Measure	Pre-/Post Difference, <i>p</i> <
Rowe, 2005*	18 hours group EFT training	Global measures of psychological distress, N = 102	Derogatis Symptom Checklist (short form)	.0005
Swingle, Pulos, Swingle, 2004*	2 EFT sessions	Traumatic stress following auto accidents, N = 9	SUD, symptom inventories	.001, .05
Lambrou, Pratt, Chevalier, 2003*	30-minute TFT session	Claustrophobia, N = 4	Speilberger State-Trait Anxiety Inv.	.001
Folkes, 2002*	1 to 3 TFT sessions	Refugees and immigrants with PTSD symptoms, N = 29	PTSD checklist Subscales: intrusive thoughts avoidance hypervigilance	.05 .05 .05 .05
Darby, 2001	1-hour TFT session	Needle phobia, N = 20	SUD, Wolpe & Lang Fear Survey	.001, .001
Sakai, et al., 2001	Average of 51.4 TFT sessions in an HMO	31 psychiatric diagnoses, N = 714	SUD	.001 for 28 conditions; .01 for the other 3

Note: EFT = Emotional Freedom Techniques; HMO = Health Maintenance Organization; PTSD = posttraumatic stress disorder; SUD = Subjective Units of Distress; TFT = Thought Field Therapy.

The other six uncontrolled outcome studies are briefly summarized in Table 2. Although these studies tend to corroborate one another, factors independent of the intervention being investigated may have been active ingredients in the observed improvements. Each also had minor to major design flaws (e.g., Rowe's, 2005, findings may have been artifacts of the intensive group experience rather than the EFT; Lambrou, Pratt, & Chevalier, 2003, had a very low N; Folkes, 2002, did not control for practitioner differences, traumatic stress histories, or multiple diagnoses; Darby, 2001, both administered the treatment and collected the data; and Sakai, et al., 2001, used only SUD self-reports). However, uncontrolled outcome studies can provide preliminary evidence that helps in making early determinations and guiding future research, and strong pre-/post-treatment improvements were consistent across these six studies.

Randomized Controlled Trials with Limited Generalizability

Four studies, summarized in Table 3, utilized randomized controlled designs. Due to various other design limitations, however, their generalizability is restricted.

Table 3: Four RCTs with Limited Generalizability

Source *= <u>peer-reviewed</u>	Treatment, N	Controls, N	Measures	Comparison
Andrade & Feinstein, 2004	Series of TFT sessions, apprx 2500 anxiety disorder patients	Series of CBT sessions, apprx 2500 anxiety disorder patients	Post-treatment interviews (interviewer blinded to treatment approach)	Stronger effect from TFT, $p < .0002$
Wade, 1990	1 TFT Session, phobias, N = 28	Wait-list, N = 25	SUD	Stronger effect from TFT, $p < .001$
Irgens, Uldal, & Hoffart (2007)	TFT treatments for social phobia, agoraphobia, or PTSD, N = 24	Wait list, N = 24	Several anxiety inventories Depression inventory	Stronger effect from TFT, .01 to .001 Ns
Carbonell & Figley, 1999*	TFT treatments of traumatic stress, N = 12	EMDR treatment of traumatic stress, N=6; Traumatic Incident Reduction (TIR), N = 5	All 3 treatments yielded similar, significant, durable reductions in anxiety on standardized measures; differences were in time required	Average (minutes): TFT = 63 EMDR = 173 TIR = 254

Note: CBT = Cognitive Behavior Therapy; EMDR = Eye Movement Desensitization and Reprocessing; HMO = Health Maintenance Organization; PTSD = posttraumatic stress disorder; RCT = Randomized Controlled Trial; SUD = Subjective Units of Distress; TFT = Thought Field Therapy; TIR = Traumatic Incident Reduction.

In the first and most extensive of these studies, eleven allied clinics in Argentina and Uruguay that had been using cognitive behavior therapy (CBT) in their treatment of anxiety introduced TFT and conducted a number of informal, in-house comparison studies between the two methods (reported in Andrade & Feinstein, 2004). In the largest of these, which was continued over a 5-1/2 year period, approximately 5,000 patients diagnosed with a range of anxiety disorders were randomly assigned to either TFT or CBT treatment. Interviewers who were blind to the treatment modality placed each patient into one of three categories at the termination of therapy: no improvement with the presenting problem, some improvement, or complete remission. Complete remission was reported by 76 percent of the patients in the TFT group and 51 percent of the CBT group ($p < .0002$). Some improvement to complete remission was reported by 90 percent of the patients in the TFT group and 63 percent of the CBT group ($p < .0002$). Another RCT with 190 patients diagnosed with specific phobias focused on the length of treatment. Seventy-eight percent of the TFT group reported partial to complete improvement at termination after a mean of 3 sessions (range 1 to 7); 69 percent of the CBT group reported partial to complete improvement at termination after a mean of 15 sessions (range 9 to 20). The superior improvement rates produced by TFT over CBT, and the fewer sessions required to achieve them, showed strong statistical significance.

Each of the RCTs summarized in Table 3 had design limitations that make its findings difficult to interpret or generalize. The data from the South America study are contaminated by a

number of factors, such as informal record-keeping, subjective outcome assessments, and variables that were not rigorously controlled. Wade's, 1990, outcome data was limited to self-reports. Irgens, Uldal, and Hoffart, 2007, did not strictly control for the introduction of other approaches in conjunction with TFT. Carbonell and Figley (1999) used a very small n distributed unevenly over the treatment conditions. Still, as with the uncontrolled outcome studies, these additional sources of preliminary evidence seem to corroborate clinical reports.

Seven Controlled Trials with Potentially Strong Generalizability

Five randomized clinical trials whose findings can more readily be interpreted and generalized have investigated EP treatments with public speaking anxiety, test-taking anxiety, weight control, post-injury anxiety and pain, and phobias of insects or small animals. A sixth RCT extended and partially replicated the phobia study. A seventh investigation used its subjects as their own controls in another partial replication of the phobia study. These seven studies are summarized in Table 4, and since they constitute a stronger type of evidence than those presented in the previous sections, they are described here in greater detail.

Table 4: Seven Controlled Trials with Potentially Strong Generalizability Showing EP to Be Statistically Superior to Other Treatment Conditions

Source *= <i>peer-reviewed</i>	Condition	Treatment, N	Controls, N	Measures	Diff. <i>p</i> <
Schoninger, 2004	Public speaking anxiety	1 TFT Session, N=24	Wait-list, N=24	SUD, Speaker Anxiety Scale, Trait/State Anxiety Scale	.001 .001 .001
Sezgin & Özcan, 2004	Test-taking anxiety	Training in EFT, N=16	Relaxation Training, N=16	Standardized test-anxiety inventory	.05
Elder, et al., 2007*	Weight loss maintenance	10 hours group TAT sessions over 12 weeks, N=27	10 hours group qigong sessions over 12 weeks, N=22	Maintenance of weight loss after 10 group sessions and then 12 weeks later	.006 .000
Korber, et al., 2002*	Anxiety, pain, and elevated heart rate following injury	Paramedic-applied acupressure before transport to hospital, N=20	Paramedic-applied sham-acupuncture N=20, No treatment, N=20	Pulse rate; Visual analog scale for anxiety pain	.001 .001 .001
Wells, et al., 2003*	Specific Phobia (partial replication of Wells)	30-min EFT Session, N=18	30-min Diaphragmatic Breathing Session, N=17	SUD, Standardized Fear Survey, Behavioral Approach Task	.005 .005 .02
Baker & Siegel, 2005	Specific Phobia (partial replication of Wells)	45-min EFT Session, N=11	45-min Supportive Counseling, N=10	SUD, Fear Questionnaire 1, 2, Behavior Approach Task	.001 .02 .001 .03
Salas, 2001	Specific Phobia (partial replication of Wells)	1 Session EFT, 1 Diaphragmatic Breathing, N=22 (half in each order)	Subjects were own controls	SUD, Beck Anxiety Inventory, Behavioral Approach Task	.01 to .001

Note: EFT = Emotional Freedom Techniques; RCT = Randomized Controlled Trial; SUD = Subjective Units of Distress; TAT = Tapas Acupressure Technique; TFT = Thought Field Therapy.

Public Speaking Anxiety. In an investigation of the efficacy of TFT with public speaking anxiety, 38 women and 10 men with self-identified public speaking anxiety were randomly assigned to a treatment group or a wait-list control group (Schoninger, 2004). Each of the 48 subjects gave an extemporaneous speech in front of a small audience and was then given self-report instruments to measure emotional responses to the public speaking experience. The

measures included the Clevenger and Halvorson Speaker Anxiety Scale, the Spielberger Trait and State Anxiety Scale, and a SUD rating. No significant differences were found between the two groups in the pretreatment measures. Subjects in the treatment group were given a single TFT session of up to an hour that focused on public speaking. They then gave another extemporaneous speech under the same conditions, followed by the same anxiety measures. Scores on all three measures were significantly lower compared with pretreatment scores ($p < .001$). Anxiety scores for the control group following a second speech (instead of treatment there was a two-week delay between speeches given by the wait-list group) increased slightly, though not significantly. The wait-list group was then given a TFT session of up to an hour. Immediate post-testing revealed improved outcome scores equivalent to those of the original treatment group. Significant pre-/post-treatment changes on the Speech Anxiety Scale included less shyness, confusion, physiological activity, and post-speech anxiety, as well as increased poise, positive anticipation, and interest in giving a future speech. On follow-up interviews four months later, the treatment outcomes appeared to have held, according to participant accounts, with more effective self-expression in varying contexts frequently being reported, though standardized instruments were not administered.

Test-Taking Anxiety. EFT was compared with Progressive Muscle Relaxation (PMR) in the self-treatment of test anxiety with a group of adolescent students taking intensive training for the preparation of the university entrance exam in Turkey (Sezgin & Özcan, 2004). Thirty-two students with elevated scores on the Turkish form of the Test Anxiety Inventory (TAI) were randomly divided into two groups ($N=16$). Each group first received a lecture on the modality being used (EFT or PMR). Students in the EFT group were then taught how to self-apply EFT tapping procedures while focusing on taking a test. Students in the PMR group received audio instruction CDs for progressive muscle relaxation, published by the Turkish Psychological Association. The groups were asked to apply EFT or PMR (as instructed in the audio CD) three times a week for the following two months, particularly at times when feeling anxiety about the test. The TAI was then re-administered (still prior to taking the entrance exam). Both groups showed a significant decrease in test-taking anxiety, but the decrease for the EFT group (mean pre-treatment score of 53.9 decreased to 33.9) was significantly greater than the decrease (56.3 to 44.9) for the PMR group ($p < .05$).

Weight Control. A study conducted by Kaiser Permanente's Center for Health Research addressed the fact that despite extensive government, professional, and community efforts, "the obesity epidemic continues to affect more than 100 million Americans. A major factor contributing to the escalating epidemic is weight regain after weight loss, which is disappointingly common" (Elder, et al., 2007, p. 68). The investigators were interested in the potential effectiveness of mind-body therapies for weight control (this study compared TAT and qigong). A weight-loss maintenance support group was used as a control condition. To be eligible for the study, participants had to have lost at least 3.5 kg during a previous 12-week group weight loss program which included social support as well as information on behavioral and motivational theories. Participants (average weight-loss was 5.33 kg) were then randomly placed into one of three weight-loss maintenance programs: TAT (focusing on issues such as the origins of the participant's weight problems or factors hindering weight loss), qigong (another intervention tracing to Traditional Chinese Medicine that combines mental and physical exercises), or a support group that surveyed weight-loss maintenance strategies and provided opportunities to share experiences and ask questions. All three treatments were matched for

intensity of contact, with each providing 10 hours of group-based contact time during the first 12 weeks of the weight-loss maintenance phase.

TAT was superior to the other two conditions for weight-loss maintenance, with TAT participants losing an additional 0.1 kg at 12 weeks and having gained only 0.1 kg at 24 weeks. Qigong participants had gained back 1.5 kg at 12 weeks ($p < .006$ compared with TAT) and 2.8 kg at 24 weeks ($p = .000$). The support group participants had gained back 0.3 kg at 12 weeks and 1.2 kg at 24 weeks, numbers that did not quite reach statistical significance compared with the TAT participants ($p < .09$ at 24 weeks). Interestingly, participants with a history of recurrent unsuccessful weight loss were more likely to gain weight if assigned to the support group, but this effect was not found in the TAT or qigong groups ($p < .03$).

Anxiety, Pain, and Elevated Heart Rate Following an Injury. A study of acupressure treatment by paramedics immediately following an injury, published in *Anesthesia & Analgesia* (Kober, et al., 2002), led to striking reductions in anxiety, pain, and elevated heart rate. While not specifically limited to TFT, EFT, or TAT, its findings are included here because it is the only RCT of an EP approach administered *in vivo*. Three treatment conditions were used to investigate the effects of acupressure on pain, anxiety, and heart rate with patients who suffered a minor injury that nonetheless required paramedics to transport them to the hospital. Condition 1 involved having the paramedic hold a set of pre-selected acupuncture points for three minutes after medical interventions were completed but before transport to the hospital. Condition 2 was identical, except the treatment involved holding areas of the skin that do not contain recognized acupuncture points (“sham” points). Condition 3 involved three minutes of waiting with no acupressure or sham acupressure applied. Sixty patients were randomly assigned to one of these three groups. An independent observer, blinded to the treatment condition, recorded vital signs and the patient’s self-assessment of pain and anxiety on a visual analog scale before the acupressure treatment and after arrival at the hospital. The treatments that used the traditional points resulted in a significantly greater reduction of anxiety ($p < .001$), pain ($p < .001$), and elevated heart rate ($p < .001$) than the other two treatment conditions.

Specific Phobias. A randomized controlled trial compared EFT with a form of Diaphragmatic Breathing (DB) in the treatment of specific phobias of insects or small animals, including rats, mice, spiders, and roaches (Wells, Polglase, Andrews, Carrington, & Baker, 2003). The DB was designed to include verbal elements similar to those of EFT. The two treatment conditions were, except for the primary variable (the physical intervention—tapping or DB), kept as similar as possible so the investigators would be able to determine whether tapping was the operative factor in any treatment gains. Volunteers recruited through newspaper and radio announcements were given an extensive telephone interview structured around the *DSM IV* criteria for specific phobia. Participants selected for inclusion matched these criteria, were not currently receiving treatment for the phobia, and agreed to be contacted for follow-up testing. Potential subjects who reported a SUD level of less than 5 while standing directly in front of the feared insect or animal (a live insect or animal was used *in vivo* for the assessment but not the treatment) were also excluded from the study.

Thirty-five participants were randomly assigned to the EFT treatment (N=18) or the DB treatment (N=17) condition. A modified form of the Brief Standard Self-Rating for Phobic Patients (using three of the four measures: Main Target Phobia, Global Phobia, and Anxiety-Depression) was administered to measure phobic symptoms and change. A Behavioral Approach Task (BAT) was designed to measure the participants’ level of avoidance of the feared animal.

Participants were assessed on how close they would allow themselves to get to the feared animal according to 8 measurement points (outside the room, door closed; outside the room, door open; inside the room at 5, 4, 3, 2 and 1 meters, and directly in front of the animal). SUD ratings were taken at each of the points the participant reached on the BAT. Experimenter demand was kept low, with participants never being encouraged to move closer to the animal. A research assistant who was blind to the person's treatment condition manually took a baseline pulse rate following completion of demographic data and once again at the point at which the client voluntarily stopped on the Behavioral Approach Task.

The treatment session, which was limited to 30 minutes and began with the experimenter providing a brief rationale for the intervention, was conducted immediately following the pretesting. After the allotted time, the treatment was stopped and post-tests were administered in the same order as the pretests, using identical measures. At follow-up, participants were retested on all measures and also given an opportunity to discuss their experiences with the researchers.

Both groups showed immediate post-treatment improvement on all 5 measures, with EFT being superior on four of them: fear questionnaire ($p < .005$), BAT ($p < .02$), SUD rating during the BAT ($p < .02$), and pre-/post-treatment SUD ($p < .005$). Pulse rate decreased about equally following both treatments. Twelve participants from the EFT condition and 9 from the DB condition were available for the follow-up testing 6 to 9 months after the treatment. Follow-up scores for the EFT group on the BAT, the SUD rating during the BAT, and the pre-/post-treatment SUD rating showed that the improvement found immediately following treatment was sustained. Scores on the fear questionnaire indicated an increase in fear since the treatment, but they were still significantly lower than the original pre-treatment scores ($p < .025$).

Specific Phobias – Replication Studies. A partial replication of the Wells study (Baker & Siegel, 2005) used randomized controls (N=11 for the EFT group, N=10 for the control group) and corroborated its findings. Baker and Siegel added a third condition, a no-treatment control group (N=10), and they changed the comparison condition from diaphragmatic breathing to a supportive interview where participants were given an opportunity to discuss their fears in a respectful, accepting Rogerian-like setting. The time allotted for the two treatment conditions was also changed, from 30 minutes to 45 minutes. EFT was superior on 5 pre-/post measures: SUD following the treatment, SUD during the BAT, the fear questionnaire, a fear of animals questionnaire designed for the new study, and the BAT (.001, .002, .02, .001, and .03 respectively), strongly supporting the findings of the original study. Where the diaphragmatic breathing treatment resulted in some improvement in the original study, participants in the supportive interview and the no-treatment control conditions of this study showed no significant changes on the questionnaire measures. As in the original study, only heart rate showed large but equal changes for both treatments. Follow-up, on average 1.4 years later, showed that the effects of EFT persisted, though in attenuated form.

An unpublished master's thesis by Salas (2001) also partially replicated the Wells study. Rather than using a control group, the 22 subjects served as their own controls, with half receiving EFT first and then DB; the other half receiving DB first and then EFT. Subjects were college students who reported having specific phobias which, to be included in the study, they rated as 8 or higher on a written SUD inventory. Phobias that did not lend themselves to the concrete testing used in the Behavioral Approach Task, such as the fear of flying, were also not included. Three measures—the Beck Anxiety Inventory, a modified BAT, and SUD ratings—were administered prior to either treatment, after the first treatment, and after the second treatment.

DB produced a significant decrease of anxiety ($p < .001$) as measured by the SUD when it was the first treatment, but not when it was the second treatment, and it did not produce significant improvement according to the other two measures, regardless of the order of the treatments. EFT produced a significant decrease of anxiety on all three measures, whether it was used as the first or second treatment. Improved SUD ratings with EFT, whether given before or after DB, were at the .001 level. Improvements in both the Beck inventory and the modified BAT were at the .001 level when EFT was administered first and at the .01 level when it was administered second.

Discussion of the Controlled Studies

Does the introduction of so-called energy methods into psychotherapy represent a passing fad, a repackaging of established modalities, or a genuine innovation? In 1993, the Society of Clinical Psychology (APA, Division 12) appointed a task force led by Dianne Chambless to consider methods for identifying effective psychotherapies and educating psychologists, insurance providers, and the general public about them. The Task Force report (Task Force on Promotion and Dissemination of Psychological Procedures, 1995), along with a series of updates and commentaries by Chambless and various colleagues, has become a standard for evaluating treatments using evidence-based criteria. The Task Force designates two categories for therapies that have sufficient empirical support: “Well-Established Treatments” and “Probably Efficacious Treatments.” The Division 12 standards are designed to isolate nonspecific therapeutic factors such as placebo, suggestion, compliance, and expectation effect? Issues such as research design, subject selection, specificity of problem or disorder, treatment implementation, outcome assessment, data analysis, replication, and the resolution of conflicting data are all discussed, and guidelines are offered for those evaluating clinical research (Chambless & Hollon, 1998).

To meet the criteria for being a “Well-Established Treatment,” the approach may demonstrate efficacy by proving itself to be statistically superior to a placebo or an unproven treatment approach in at least two well-designed, peer-reviewed studies conducted by different investigators or investigating teams (Chambless, et al., 1998). Having one such study in the literature meets the criteria for being a “Probably Efficacious Treatment.” Two additional criteria for either category include that the client sample must be clearly specified and that treatment implementation must be uniform, either through the use of manuals or other means, such as when a treatment intervention that is relatively simple “is adequately specified in the procedure section of the journal article testing its efficacy” (Chambless & Hollon, 1998, p. 11).

The Wells EFT study (Wells, Polglase, Andrews, Carrington, & Baker, 2003) and the Kaiser TAT study (Elder, et al., 2007) each brings EP past the threshold formulated by the Division 12 Task Force, establishing EFT as a “Probably Efficacious Treatment” for specific phobias and TAT as a “Probably Efficacious Treatment” for maintaining weight loss (although Division 12 has not yet evaluated either study in published reports). Each is a well-designed, randomized, peer-reviewed investigation. The Wells study demonstrated that a session of imaginal exposure plus tapping was statistically superior to a session of imaginal exposure plus diaphragmatic breathing in treating phobias of insects and small animals. The Kaiser study, comparing two mind-body approaches, demonstrated that TAT was significantly more effective than qigong for maintaining weight loss over 24 weeks.

Unresolved Issues

Beyond the additional research needed to more firmly establish the efficacy of EP, several additional questions call for focused investigation. Pressing among these are the need for better understanding of the mechanisms involved in EP treatments, the use of EP with complex psychological problems, and the conditions for which EP is most likely to be effective.

Mechanisms. The distinctive mechanisms of action of EP—beyond elements common to most clinical approaches, such as building a therapeutic alliance—are increasingly being explained by EP practitioners according to principles underlying exposure treatment combined with principles underlying acupuncture. Exposure treatment, beyond reducing hyperarousal in the moment, is built upon the principle that whenever a memory is accessed, it must then be reconsolidated into the person’s neurology and cognitive system (Garakani, Mathew, & Charney, 2006). While consolidation, the process by which newly learned information is stored, was at one time believed to occur only at the time of the experience, a research program at New York University led by Joseph LeDoux has demonstrated that “consolidated memories, when reactivated through retrieval, become labile (susceptible to disruption) again and undergo reconsolidation” (Debiec, Doyere, Nader, & LeDoux, 2006, p. 3428). That is, when a memory is retrieved, it can then be altered (including changes in the limbic responses it evokes) before it is stored again. This process is an essential ingredient for all forms of exposure therapy.

But *in vivo* or imaginal exposure is not in itself sufficient to insure therapeutic change. Between the exposure that activates the associated emotions and reconsolidation of the experience, the limbic response must be altered. In CBT, this might be accomplished through relaxation techniques or through multiple exposures paired with positive self-statements, ultimately leading to extinction. In EP, it is accomplished by manually stimulating a set of acupuncture points that are believed to bring about therapeutic shifts in neurochemistry. MRI studies have, in fact, shown that stimulating certain acupuncture points decreases activation signals in areas of the amygdala and other brain structures involved with fear (Hui, et al., 2000).

In brief, combining two seemingly unrelated laboratory findings leads to an explanation for the observed effects of EP interventions with anxiety disorders: 1) acupoint stimulation during episodes of hyperarousal can send deactivation signals to brain structures that regulate affect and 2) evoked memories need to be reconsolidated. When a memory or thought that triggers limbic hyperarousal is evoked, and acupoints that decrease activation signals in the amygdala and related brain areas are simultaneously stimulated, hyperarousal is reduced. When the memory or thought is then reconsolidated, the strength of its ability to trigger hyperarousal remains diminished, leading (after a number of exposures to the procedure) to the extinction of the elevated limbic response. Although this hypothesis has not itself been empirically validated, it is built upon established research findings and offers a plausible explanation for reports of rapid reduction of anxiety following the use of EP.

Treating Complex Clinical Conditions. Another unresolved question is the use of EP with psychological problems that are more complex than specific phobias or other conditioned responses. Most of the existing studies of EP are based on single-session treatments of relatively circumscribed problems such as specific phobias or public-speaking anxiety. In actual practice, EP treatments for more complex conditions typically require multiple sessions. These often involve the identification and treatment, one by one, of numerous conditioned response pairings. A complex problem is divided into components or aspects, such as triggers for the problematic

response, early experiences associated with the problematic situation, irrational beliefs that maintain the problem, or highly specific elements of a traumatic memory, such as the sound of screeching tires prior to an automobile collision (Feinstein, Eden, & Craig, 2005). Unrecognized conflict about attaining the treatment goal is another frequent focus during EP treatments. EP interventions with complex problems may readily be (and often are) combined with other treatment approaches. Studies comparing standard treatments for difficult diagnoses with and without adjunctive EP interventions would, in fact, do much to establish whether EP has efficacy with complex clinical conditions. Meanwhile, preliminary impressions about the specific conditions and client populations for which EP might be indicated are available.

Conditions for Which EP is Most Likely to Be Effective. The only systematic data on the conditions for which EP may be most effective is based on surveys of practitioners. A doctoral study of therapist perspectives on the use of EP in treating adult survivors of childhood sexual abuse surveyed 12 licensed psychologists in private practice (9 female, 3 male) ranging in age from 43 to 67 years old (Schulz, 2007). All 12 utilized EP. Six had been licensed more than 20 years, and all had been licensed more than 5 years. EP was the primary modality used by 5 of them with adult survivors of childhood sexual abuse. The other 7 combined EP with talk therapy, CBT, and/or EMDR. All 12 reported believing that EP is the most effective approach available for the anxiety, panic attacks, and phobias found in adult survivors. All 12 also reported observing improved mood, self-esteem, and interpersonal relationships when using EP with this population. 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.

Their impressions about EP outcomes with anxiety, panic attacks, phobias, and improved mood are consistent with two other EP practitioner surveys, one originating in North America, the other in South America (see http://energymed.org/pages/ep_survey.htm). Both groups reported believing that EP was more effective than the other approaches available to them in treating most anxiety disorders, including the hyperarousal found in PTSD, and many of the most common emotional difficulties of everyday life, from inappropriate anger to excessive feelings of guilt, shame, grief, jealousy, and rejection. They also identified conditions for which they believed combining EP with more conventional treatments produced more rapid outcomes than the conventional treatment alone, including mild to moderate reactive depression, obsessive-compulsive disorders, learning skills disorders, borderline personality disorder, eating disorders, and substance abuse. While only suggestive, the three surveys identify conditions and populations for which applications of EP might be productively investigated.

Conclusion

Energy psychology integrates methods from acupuncture and other non-Western healing traditions into contemporary clinical practice. Although an abundance of anecdotal evidence, uncontrolled outcome studies, and non-peer-reviewed investigations reflect favorably upon the approach, only two peer-reviewed RCTs comparing the most well-established EP protocols with other modalities can be found in the literature. These RCTs, however, meet APA Division 12 criteria establishing a form of EP as a “probably efficacious treatment” for specific phobias and another as a probably efficacious treatment for maintaining weight loss. While further research on efficacy, mechanisms, and indicated disorders is clearly required, extensive clinical reports combined with the limited scientific evidence suggest that EP holds promise as a rapid and potent treatment for a range of psychological conditions.

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