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Energy Psychology in Disaster Relief

David Feinstein, Ph.D.

Abstract

Energy psychology utilizes cognitive operations such as imaginal exposure to traumatic memories or visualization of optimal performance scenarios—combined with physical interventions derived from acupuncture, yoga, and related systems—for inducing psychological change. While a controversial approach, this combination purportedly brings about, with unusual speed and precision, therapeutic shifts in affective, cognitive, and behavioral patterns that underlie a range of psychological concerns. Energy psychology has been applied in the wake of natural and human-made disasters in the Congo, Guatemala, Indonesia, Kenya, Kosovo, Kuwait, Mexico, Moldavia, Nairobi, Rwanda, South Africa, Tanzania, Thailand, and the U.S. At least three international humanitarian relief organizations have adapted energy psychology as a treatment in their post-disaster missions. Four tiers of energy psychology interventions include 1) immediate relief/stabilization, 2) extinguishing conditioned responses, 3) overcoming complex psychological problems, and 4) promoting optimal functioning. The first tier is most pertinent in psychological first aid immediately following a disaster, with the subsequent tiers progressively being introduced over time with complex stress reactions and chronic disorders. This paper reviews the approach, considers its viability, and offers a framework for applying energy psychology in treating disaster survivors.

Key words: acupuncture, energy psychology, Emotional Freedom Techniques, hyperarousal, Thought Field Therapy, trauma.

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David Feinstein, Ph.D.

Energy psychology, as most commonly practiced in clinical and post-disaster situations, 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 or 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.

While empirical validation for the effectiveness of the use of acupressure points in energy psychology is still in a relatively early stage, striking treatment successes in the aftermath of severe trauma are being reported by a broad range of credible sources, giving the psychotherapy community cause to assess the method before conclusive research is available. This paper offers a context for such inquiry as well as a framework for applying EP following natural and human-made disasters.

Four Tiers of EP

The efficacy and mechanisms of EP have been matters of controversy (Feinstein, in press), and even as basic a question as whether EP is an isolated technique, equivalent for instance to systematic desensitization, or a more comprehensive psychotherapy, has been an area of confusion. A review of the major EP texts (e.g., Callahan & Trubo, 2002; Diepold, Britt, & Bender, 2004; Feinstein, 2004; Feinstein, Eden, & Craig, 2005; Gallo, 2002; Gallo, 2004; Mollon, 2008) shows four tiers of EP interventions: immediate relief/stabilization, extinguishing conditioned responses, overcoming complex psychological problems, and promoting optimal functioning:

1. Immediate Relief/Stabilization. Much as a paramedic might instruct a patient having an anxiety attack in a breath control technique that is incompatible with hyperventilation, EP

utilizes *in vivo* interventions believed to be incompatible with limbic hyperarousal. Tapping on specified acupuncture points whose stimulation has been shown to decrease activation signals in the amygdala (Hui, et al., 2000), for instance, appears to rapidly decrease elevated emotional responses in stressful situations. This simple procedure is proving itself to be a potent intervention for providing psychological first aid in the immediate aftermath of disaster.

2. *Extinguishing Conditioned Responses.* Similar techniques are applied for extinguishing a maladaptive conditioned response, such as a phobia or irrational rage. EP exposure treatments target the response to internal or external cues that trigger dysfunctional fear, aggression, or avoidance. By eliminating the limbic hyperarousal caused by the triggering cue, associated problematic affective, cognitive, and behavioral patterns may be interrupted.

3. *Overcoming Complex Psychological Problems.* An EP approach identifies and targets salient aspects of complex problems. Aspects of low self-esteem, for instance, might include unresolved memories of parental emotional abuse, self-defeating beliefs, exaggerated appraisals of interpersonal threat, and anxiety in social situations. The combination of acupoint stimulation with the mental activation of carefully selected scenes, feelings, or beliefs may be applied to the elements of a complex psychological problem, one by one.

4. *Promoting Optimal Functioning.* Beyond its uses in helping people cope with and overcome psychological problems, EP interventions may be applied to alter self-concept, affect, and motivation in ways that promote confidence, optimism, courage, peak performance, social skills, and feelings of spiritual connectedness.

At these third and fourth tiers, EP is often integrated with other clinical or personal development approaches. In treating obsessive-compulsive disorders, for instance, strategies from Cognitive Behavior Therapy (CBT) may provide a framework as EP techniques are employed for rapidly reducing activation in response to specific cues. In enhancing personal resilience, strategies from Positive Psychology (such as the “building of buffering strengths” like perseverance or a capacity for pleasure, Seligman, 2002, pp. 6 - 7) may provide a framework as EP techniques are employed to instill such strengths.

EP includes a variety of protocols (at least two dozen variations have been identified) that generally fall within the field of *energy medicine* (Feinstein & Eden, 2008), much as psychiatry is a specialty within conventional medicine. Energy medicine is recognized by the National Institutes of Health (NIH) as a form of “complementary and alternative medicine” that is based on the supposition that illness results from disturbances in the body’s electromagnetic energies and energy fields (National Center for Complementary and Alternative Medicine of NIH, 2005). *Energy psychology* focuses on these energies for the purpose of alleviating psychological problems and pursuing personal goals. The most well-known variations are Thought Field Therapy (TFT), the Emotional Freedom Techniques (EFT), and the Tapas Acupressure Technique (TAT). TFT is one of the earliest formulations of EP, developed in the 1980s by Roger Callahan. EFT is a streamlined variation of TFT that can be used by the general public outside clinical settings, originated by Gary Craig after studying with Callahan. TAT was developed by acupuncturist Tapas Fleming. All three utilize non-needle methods of stimulating acupuncture points (acupoints) for the purpose of inducing positive psychological change. TFT, EFT, and TAT have been by far the most widely utilized and investigated EP approaches and will be the focus of this paper.

Controversies

As an approach whose procedures may look patently strange (such as tapping on the back of one's hand while humming a tune), whose explanatory models are derived from paradigms based in another culture, and whose advocates have made strong claims of efficacy without adequate research validation, EP has been exceedingly controversial among psychotherapists. Ray Corsini, editor of one of the few standard psychology texts to mention EP, 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" (2001, p. 689). The Continuing Professional Education Committee (CPEC) of the Education Directorate of the American Psychological Association (APA), developed a special regulation for EP that leans toward the "hoax" appraisal. Rather than following its usual procedure of having APA CE sponsors make their own determinations about a new approach according to established CPEC guidelines, the Committee took the unprecedented step in 1999 of notifying its CE sponsors by a memo that they risked losing their sponsorship status if they offered APA CE credit for courses in TFT (Murray, 1999). This policy was still in effect at the time of this writing and had been broadened to include all energy psychology courses.

Nonetheless, the number of therapists incorporating its methods into their practices has been increasing steadily since the approach was introduced in the 1980s. *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). 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. An international professional organization, the Association for Comprehensive Energy Psychology (<http://www.energypsych.org>), was incorporated in the U.S. in 1999 and has developed a comprehensive certification program and ethics code. A review of one of EP's major texts (*Energy Psychology Interactive*; Feinstein, 2004) in the APA's online book review journal describes energy psychology as "a new discipline that has been receiving attention due to its speed and effectiveness with difficult cases" (Serlin, 2005). The review, by a former APA division president, 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."

Evidence

Although the evidence is still preliminary and the number of randomized clinical trials limited, energy psychology has reached the minimum threshold for being considered an evidence-based therapy, with EFT having met the APA Division 12 criteria as a "probably efficacious treatment" for specific phobias and with TAT having met the "probably efficacious" criteria for maintaining weight loss (Feinstein, in press). Imaginal exposure *plus acupoint tapping* was shown, for instance, to be superior to imaginal exposure *plus diaphragmatic breathing* in treating phobias of bugs and small animals (Wells, Polglase, Andrews, Carrington, & Baker, 2003). Three well-designed randomized clinical trials have shown a single EFT session to be more effective than other treatment conditions in alleviating specific phobias, another has shown EP to be effective for treating public speaking anxiety, another for test-taking anxiety, and

another in weight control (reviewed in Feinstein, in press). Four additional randomized clinical trials surveyed in the same review reported statistical superiority in speed or effectiveness between EP and another treatment or wait-list condition, but experimental design flaws led the reviewer to categorize each study as having limited generalizability. Two large exploratory outcome studies that did not use control conditions and were published without peer-review (Andrade & Feinstein, 2004; Sakai, Paperny, Mathews, Tanida, Boyd, & Simons, 2001) found EP to produce strong subjective improvement on a spectrum of anxiety disorders and a wide range of other non-psychotic psychiatric conditions. Most research on EP, however, has been limited to anxiety-related disorders, and no randomized clinical trials have been conducted specifically in the treatment of disaster survivors.

Reports from the field, however, show a pattern of strong outcomes following the use of EP both immediately following disasters and in the subsequent treatment of PTSD. Hundreds of reports track the use of EP in the aftermath of wars and ethnic cleansing. Many of these accounts corroborate one another in terms of rapid relief and long-term benefits, yet the state of the art in applying EP following disasters still resides largely with the practitioners who have been carrying out such work. The author interviewed eight EP practitioners who are associated with disaster relief organizations and engaged in e-mail dialogue with the leadership of three of those disaster relief organizations. The purpose of these interviews was to attempt to find where consensus exists among experienced practitioners regarding post-disaster uses of EP and also to collect anecdotal evidence from the field. While such anecdotal reports are only a preliminary form of evidence, they are consistent and compelling enough to warrant attention. Several of these cases are posted at <http://www.ed-em.com/ep-trauma-cases.htm>.

In one report, the industrial coordinator for Pittsburgh's Critical Incident Stress Management team describes the psychological symptoms and rapid response to EP in a variety of workers who have been involved in the accidental deaths of colleagues and friends. In another report, a disaster worker who utilizes EP describes the almost instant amelioration of symptoms of shock with two women hospitalized for injuries sustained three days earlier during the 1998 bombing of the U.S. embassy in Nairobi. In a third, a social worker details the successful three-session treatment of debilitating PTSD symptoms with a woman who had been a close bystander during the World Trade Center bombings.

Carl Johnson, a clinical psychologist retired from a career as a PTSD specialist with the Veteran's Administration (V.A.) has, for nearly two decades, frequently traveled to the sites of some of the world's most terrible atrocities and disasters to provide psychological support using EP methods. About a year after NATO put an end to the ethnic cleansing in Kosovo, Johnson found himself in a trailer in a small village where the brutalities had been particularly severe. A local physician who had offered to refer people in his village had posted a sign that treatments for war-related trauma (nightmares, insomnia, intrusive memories, inability to concentrate, et cetera) were being offered. Johnson described how, as a line of people had formed outside of the trailer, the referring physician told him, with some concern, that everyone in the village was afraid of one of the men who was waiting outside for treatment.

The others in the line had actually positioned themselves as far away from this man as possible. Johnson asked the physician to invite the man into the trailer. Johnson, who after a career in the V.A. is seasoned in working with war veterans, recalled that the man "had a vicious look; he felt dangerous." But he had come for help, so with the physician translating, Johnson asked the man to bring to mind his most difficult memory from the war. Everyone in the village

was haunted by traumas of unspeakable proportion: torture, rape, witnessing the massacre of loved ones. As the man brought the trauma to mind, his face tensed and reddened and his breathing quickened. Though he never put his memory into words, the treatment began. Johnson tapped on specific acupoints that he determined to be relevant to the trauma. He then instructed the man, through the interpreter, to do a number of eye movements and other simple physical activities designed to accelerate the process. Then more tapping. Within fifteen minutes, according to Johnson, the man's demeanor had changed completely. His face had relaxed and his breathing normalized. He no longer looked vicious. In fact, he was openly expressing joy and relief. He initiated hugs with both Johnson and the physician. Then, still grinning, he abruptly walked outside, jumped into his car and roared away, as everyone watched perplexed.

The man's wife was also in the group waiting for treatment. In addition to the suffering she had faced during the war, she had become a victim of her husband's rage. The traumas she identified also responded rapidly to the tapping treatment. About the time her treatment was completed, her husband's car roared back to the waiting area. He came in with a bag of nuts and a bag of peaches, both from his home, as unsolicited payment for his treatment. He was profuse and appeared gleeful in his thanks, indicating that he felt something deep and toxic had been healed. He hugged his wife. Then, extraordinarily, he offered to escort Johnson into the hills to find trauma victims who were still in hiding, too damaged to return to life in their villages, both his own people—ethnic Albanians—and the enemy Serbs. In Johnson's words, "That afternoon, before our very eyes, we saw this vicious man, filled with hate, become a loving man of peace and mercy." Johnson further reflected how often this would occur, that when these traumatized survivors were able to gain emotional resolution on experiences that had been haunting them, they became markedly more loving and creative. While survivors, even after a breakthrough session like this, are still left with the formidable task of rebuilding their lives, the treatment disengaged the intense limbic response from cues and memories tied to the disaster, freeing them to move forward more adaptively.

The 105 people treated during Johnson's first five visits to Kosovo, all in 2000, had each been suffering for longer than a year from the post-traumatic emotional effects of 249 discrete, horrific self-identified incidents. For 247 of those 249 memories, the treatments (using TFT) successfully reduced the reported degree of emotional distress not just to a manageable level but to a "no distress" level ("0" on a 0-to-10 "Subjective Units of Distress" scale, after Wolpe, 1958). Although these figures strain credibility, they are consistent with other reports (see below). Approximately three-fourths of the 105 individuals were followed for 18 months after their treatments and showed no relapses—the original memory no longer activated self-reported or observable signs of traumatic stress (Johnson, Mustafe, Sejdić, Odell, & Dabišević, 2001).

Johnson made a total of nine trips to Kosovo between February 2000 and June 2002. His later visits were as much to train local health care providers in TFT as to treat additional patients. The follow-up information on approximately 75 percent of the people he worked with during his first five visits came primarily from physicians who had identified traumatized individuals from their practices and participated as translators in the initial TFT treatments. Since they continued to care medically for the individuals, they were able to provide follow-up on the TFT sessions. Their reports consistently suggested that once a memory had been cleared of its emotional charge, it remained clear, though other memories might subsequently be presented for treatment. The initial session, however, appeared to have durably neutralized the hyperarousal to the traumatic memories that were identified along with producing marked improvement in overall

coping and sense of well-being. Reports of these outcomes came to the attention of the chief medical officer of Kosovo (the equivalent of the U.S. Surgeon General), Dr. Skkelzen Syla (himself a psychiatrist), who investigated them and subsequently stated in a letter of appreciation on January 21, 2001:

Many well-funded relief organizations have treated the posttraumatic stress here in Kosova. Some of our people had limited improvement but Kosova had no major change or real hope until . . . we referred our most difficult trauma patients to [Dr. Johnson and his team]. The success from TFT was 100% for every patient, and they are still smiling until this day [and, indeed, in the follow-ups, each was free of relapse].

Johnson kept a simple but ultimately provocative set of statistics during his visits to Kosovo and other areas of ethnic cleansing, warfare, and natural disasters. He tracked the number of people treated, the number of traumatic incidents identified, and the number of incidents where full relief was reported (i.e., hyperarousal to the traumatic memory was completely neutralized according to the person's subjective report). Table 1 shows his tally.

Table 1: *Johnson's Tally of Energy Psychology Treatment Outcomes Following Disasters*

Country	# of Clients	# of Traumas Identified	# Resolved
Kosovo	189	547	545
South Africa	97	315	315
Rwanda	22	73	73
Congo	29	78	77
TOTALS	337	1016	1013

Johnson, who holds diplomate status with the American Board of Professional Psychology, acknowledges that such figures raise even his own skepticism. While recognizing that “well-controlled research is essential before results like these can be accepted,” he affirms that the figures accurately reflect his experiences and that he “recorded them exactly according to what happened.” After interviewing Johnson, the author of this paper interviewed several therapists who worked on these teams, and their reports corroborate Johnson’s. Johnson emphasizes that reducing the impact of traumatic memories with EP, as reflected in the above numbers, is not the end of a person’s healing journey. “Often,” however, “it is a new beginning,” providing people an opportunity to rebuild their lives without the oppressive emotional weight of their traumatization. To this end, Johnson takes great care to integrate the EP treatment into the context of the local culture’s values, social structure, family relationships, and healing traditions to support continued healing and follow-up.

As well as being corroborated by interviews with the therapists who worked with Johnson in Kosovo and in Africa, Johnson’s reports are also consistent with what other disaster

workers are describing. Clinicians from a wide range of backgrounds are reporting that EP treatments can rapidly clear much of the emotional overwhelm associated with traumatic memories. For example, 29 low-income refugees and immigrants living in the U.S. who were categorized as having the symptoms of PTSD based on having met a cut-off score on the Posttraumatic Checklist-C (PCL-C) were reporting significantly less avoidance, intrusive thoughts, and hypervigilance ($p < .05$ for each measure) after one to three sessions of TFT (Folkes, 2002).

Particularly poignant are reports that have been coming in from the Trauma Relief Committee of the Association for Thought Field Therapy Foundation about their work with the El Shadai orphanage in Rwanda. Many of the children had seen their parents 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 cut-offs. 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).

Lynn Garland, a social worker with the Veterans' Healthcare System in Boston, reports that she, along with numerous colleagues using EP 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). Members of the TFT Trauma Relief Committee have utilized TFT while providing disaster response services in more than a dozen countries, with strong results, consistent with those in Table 1, being reported (N. Gairdner, personal communication, November 30, 2005). The Humanitarian Committee of the Association for Comprehensive Energy Psychology (ACEP) reports corresponding observations based upon its work with some 300 tsunami victims in Southeast Asia (J. Hartung, personal communication, January 14, 2006). While systematic follow-up was not conducted, the ACEP group—drawing from TFT, EFT, and TAT—describes strong, rapid responses to the psychological aftermath of the disaster, including alleviating anxiety, depression, anger, and physical pain, as well as the successful resolution of earlier traumatic memories activated by the tsunami experience.

TAT (<http://www.tatlif.com>) was also used following the 2006 earthquake in Indonesia, applied by local relief workers who were provided seminars in the method's disaster relief protocol. Widespread reports of rapid relief led to some 6,000 adults and children receiving the treatment in individual and group settings. TAT has also been used following other natural disasters. Ignacio Jarero, President of the Mexican Association for Crisis Therapy, reports (on the TAT site) the use of TAT with 1,652 children after natural disasters in Mexico, Nicaragua, Colombia, and Venezuela, and its use as an adjunct to training with 642 front line service personnel in those countries. He states, "Children and adults reported significant reductions in

SUDS at the completion of the protocol. . . . TAT is our favorite technique to reduce distress because it is easy to teach and apply.”

The Green Cross (The Academy of Traumatology’s humanitarian assistance program), which deploys counselors to disaster areas with a focus on alleviating the psychological consequences of trauma, is increasingly employing EP methods. The program, founded in 1995 in response to the Oklahoma City bombings, has recently been working closely with TFT Trauma Relief Committee and the ACEP Humanitarian Committee to expand the number of available relief workers trained in EP methods. According to Green Cross 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).

A Framework for Post-Disaster Applications of Energy Psychology

A landmark international conference, organized with the intention of developing consensus on the best practices for early psychological interventions following mass violence, was held six weeks after the September 11, 2001, NYC bombings (though it had been scheduled long before that date). An anthology that reports on and furthers the work initiated by the conference (Ritchie, Watson, & Friedman, 2006) provides consensual and evidence-based guidance to mental health workers on how to proceed in the wake of mass violence and other disasters. These reports were used in formulating the following clinical guidelines for applying EP in the aftermath of natural and human-made disasters. For context, also consider the UN Inter-Agency Standing Committee’s (2007) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, a widely respected resource that includes 25 “action sheets” on how to implement a coordinated community response to mental health needs in the midst of emergencies.

Who to Treat? About 95 percent of people exposed to a traumatic event will experience some posttraumatic psychological distress (Ritchie, Watson, & Friedman, 2006), and a review of 160 studies on disaster survivors suggests that one-third will develop a clinically significant chronic psychiatric disorder (Norris, Friedman, & Watson, 2002). Estimates of the numbers that will develop PTSD or other disorders that will persist for more than a year after the traumatic event range from 11 to 15 percent (Young, 2006) to 30 percent (Ritchie, Watson, & Friedman, 2006). One possible source of these differences is that the proportion of terrorism survivors who experience clinically significant psychological distress appears to be considerably higher than that for survivors of natural disasters. For refugees, who in addition to trauma face displacement, the proportion who develop PTSD is estimated at 30 to 50 percent (Kluft, Bloom, & Kinzie, 2000).

Existing studies show that most people exposed to highly traumatic events experience symptoms of posttraumatic stress or briefly incapacitating reactions, with some of them being launched into the initial stage of a chronic and potentially incapacitating psychiatric disorder. But we do not currently have reliable models for distinguishing “vulnerable from resilient individuals immediately after a terrorist attack, mass casualty, or natural disaster” (Ritchie, Watson, & Friedman, 2006, p. 9). Nor is there evidence suggesting that active psychotherapy immediately

after a disaster would benefit either group. Numerous other types of early mental health interventions, however, have been developed.

Types of Interventions. Models of early intervention following violence or disasters have developed in response to special situations or populations, such as for soldiers in combat, high risk occupations (e.g., police, firefighters, and emergency medical personnel), rape survivors, survivors of accidents and assaults, and entire communities following a disaster (Ruzek, 2006). Combat psychiatry, for instance, has been evolving since World War I and is oriented toward reducing psychological distress and getting personnel to return to combat. The principles that have endured (known by the acronym PIES) include 1) *proximity*—administer the treatment close to the traumatic event, 2) *immediacy*—administer the treatment as soon as possible after the onset of symptoms, 3) *expectancy*—convey that a crisis reaction is normal and a quick return to the unit is expected, and 4) *simplicity*—keep the interventions easy to deliver and understand. The pragmatic outcome of getting soldiers to return to combat is well established, but the effectiveness of PIES in reducing longterm damage of trauma has received little empirical examination.

In fact, some psychological interventions immediately following disasters, such as Critical Incident Stress Debriefing, have had unanticipated negative effects (Litz, Gray, Bryant, & Adler, 2002). Debriefing did not prevent vulnerable individuals from subsequently developing PTSD, inadvertently pathologized normal stress reactions, and sometimes interfered with people's natural coping mechanisms. Some individuals are better served by a period of denial so they can rest and recover emotionally before attempting to process a severe trauma. Early interventions may open previous unresolved traumas during a period when the individual is least equipped to reconsolidate them. Some early interventions have also coerced individuals who are uneasy about disclosing personal information into sharing in ways that have negative consequences on their sense of self-worth as well as on their ongoing relationships with co-workers who might be involved in these disclosures. With the unanticipated negative effects of Critical Stress Debriefing often being cited, active psychotherapies that elicit emotional processing or detailed trauma narratives are generally not recommended immediately following a disaster. Ritchie, Watson, and Friedman (2006), for instance, caution against providing therapies whose unintended message is to pathologize normal and transient posttraumatic distress while interfering with the person's innate coping mechanisms.

Cognitive Behavior Therapy and Eye Movement Desensitization and Reprocessing (EMDR) are the only widely-recognized evidence-based treatments for PTSD (American Psychiatric Association, 2004; Britain's National Institute for Clinical Excellence, 2005). While the efficacy of CBT following other traumas is well established, there is no study of its use with disaster survivors, and recommendations about its use immediately following a disaster are offered with caution. Young, for instance, suggests that "subtle, supportive, and judicious use of cognitive reframing techniques may serve as a preliminary effort to help counter the potential negative effects of cognitive distortions" (2006, pp. 114 – 115). Ritchie, Watson, and Friedman advise that "focused cognitive interventions may be best initiated at least several weeks and possibly months after the trauma for those individuals still experiencing significant symptoms" (2006, p. 10).

While EMDR has demonstrated efficacy with PTSD following disasters, such as after the 1999 earthquake in Marmara, Turkey (Konuk, Knipe, Eke, Yuksek, Yurtsever, & Ostep, 2006), it is generally not applied immediately after a disaster. Concerns about retraumatizing the client

have been an issue in the use of EMDR, and increasing numbers of EMDR practitioners are incorporating EP into their work with traumatized individuals, finding that EP methods "help a client to process trauma more efficiently" (Hartung & Galvin, 2003, p. xix).

Although the active ingredients in the demonstrated efficacy of EMDR are a matter of debate (Bryant & Litz, 2006), exposure methods are key components of EMDR and CBT, as well as EP. EP practitioners have several ways of modulating exposure. While EP does use imaginal exposure and *in vivo* contact, the level of distress due to imaginal exposure can be reduced by having the client "see" the scene through the wrong end of binoculars, by the use of "reminder phrases" instead of imagery, and by the "tearless trauma technique," in which the client is thinking about what it would feel like to *think* about the situation (Feinstein, Eden, & Craig, 2006). All seem responsive to tapping. Of the interviews conducted for this paper, several of the EP practitioners had also been trained in EMDR. Their comments suggested that 1) EP provides greater flexibility in the range of issues that can be addressed, 2) its methods can be more readily modulated by the practitioner to allow better pacing with the client, and 3) this greater flexibility and modulation greatly reduce the chances of retraumatization or abreaction often experienced with EMDR.

Counterintuitive Findings. Several counterintuitive aspects of early interventions have been identified. Levine (1997) has shown that people (as well as animals) who shake and quiver after a trauma are less likely to develop PTSD symptoms, so holding and invasively soothing a person who is shaking may actually interfere with recovery. Debriefing—where trauma survivors share, within a supportive professional context, their experiences, thoughts, and emotional reactions with colleagues and friends who were involved in the same trauma—would seem to make a great deal of intrinsic sense. Yet strong evidence shows that it can interfere with natural coping strategies in resilient people and increase rather than prevent PTSD incidence in vulnerable individuals. Ruzek (2006) discusses several assumptions at the core of various intervention models that should be examined rather than uncritically accepted.

For instance, early intervention mental health education often attempts to "normalize" acute stress reactions. This validates the natural resilience of survivors and helps them understand that their responses are normal and transient rather than signs of personal weakness or mental illness. It serves individuals for whom acute distress symptoms are going to be transient, and may be therapeutic since many affected individuals are highly suggestible immediately following a trauma. But it may also create negative consequences for survivors whose symptoms persist. Research on survivors of mass violence, in fact, shows high percentages with enduring problems, so overemphasis on the fact that most symptoms of acute stress reactions following trauma will spontaneously dissipate over time may stigmatize people who need treatment and ultimately keep them from receiving it. Another assumption, which traces back to combat psychiatry, is that it is important for mental health specialists to actively intervene as soon as possible after the trauma. Various outcome studies, however, along with concerns about pathologizing normal reactions, give "reason to question whether intervening sooner will result in better care" (Ruzek, 2006, p. 20). Common-sense assumptions about working with disaster survivors have sometimes been refuted by clinical observation, and the most viable working assumptions 24 hours after a disaster may be substantially different from the most viable working assumptions three weeks later.

Applications of EP following a disaster must be calibrated to the unique needs and constraints of each individual and to an understanding of the kinds of intervention that are

appropriate at various timeframes after the disaster. Ritchie, Watson, and Friedman (2006) include chapters discussing principles for immediate responses to disaster (Ruzek, 2006; Ørner, Kent, Pfefferbaum, Raphael, & Watson, 2006; Young, 2006), interventions one to four weeks after exposure to a trauma (Bryant & Litz, 2006), and longer-term interventions (Raphael & Wooding, 2006).

Immediate Responses to a Disaster. Beyond attending to basic needs such as safety, security, food, shelter, and medical problems directly following a disaster, psychological first aid is defined as “the use of pragmatic-oriented interventions delivered during the immediate-impact phase . . . to individuals who are experiencing acute stress reactions or who appear at risk for being able to regain sufficient functional equilibrium by themselves, with the intent of aiding adaptive coping and problem-solving” (Young, 2006, p. 134). Psychological first aid is meant to be administered within the context of a larger emergency response that includes community-level assessments and responses to mental health and public health needs. While psychological first aid following disasters has not been empirically tested, it is composed of empirically defensible interventions and is “considered ‘safe’ because it does not focus on emotional processing or detailed trauma narratives, is not meant to be ‘mandatory,’ and should only be used” with individuals who exhibit extreme acute distress reactions or notable risk factors associated with adverse post-disaster mental health outcomes (Young, 2006, p. 135).

After establishing safety and providing basic support and mental health information relevant to the disaster, early mental health responses involve:

- 1) interventions that address specific traumatic stressors
- 2) interventions that reduce arousal
- 3) directing survivors to additional resources through problem-solving and referral

Specific stressors may include the violent unexpected death of a loved one, witnessing grotesque injuries and death, and loss of critical resources, along with ongoing intrusive images and cognitive distortions that increase distress and maintain an exaggerated sense of threat. Arousal reduction interventions might include education about stress reactions, stress management techniques, and resources; relaxation techniques; cognitive reframing techniques for countering the potential negative effects of cognitive distortions; and psychopharmacological interventions (Young, 2006).

EP is applicable at numerous points within this framework, with particular strengths, according to its practitioners, in the areas of reducing arousal, subduing intrusive memories, stress management, and cognitive restructuring. EP practitioners who are experienced with providing immediate disaster responses tend, however, to be less conservative than Young (and the literature in general) in terms of suggested constraints on emotional processing and eliciting detailed trauma narratives. Such cautions have become prominent in disaster mental health strategies since the negative impact of debriefing has been fully recognized. EP interventions, however, incorporate strategies that practitioners are claiming mitigate these concerns.

Jim McAninch, of Pittsburgh's Critical Incident Stress Management (CISM) team, is often on the scene within hours following accidents that involve fatalities. The mandate of the CISM team includes facilitating “normal recovery process of normal people having normal, healthy reactions to abnormal events.” Like most community disaster response programs, McAninch’s team is explicitly *not* meant to provide psychotherapy or to substitute for

psychotherapy, yet its stated goals include therapeutic objectives that would fall within the parameters of psychological first aid and other early mental health interventions. McAninch's administrative supervisor was at first highly skeptical about the utilization of EP as part of the CISM disaster response. However, enough instances have now been logged in which TFT was judged to have 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 Pittsburgh CISM Team.

McAninch typically has those who were directly involved in the accident recount or mentally replay what they witnessed, sometimes one-on-one and sometimes with other witnesses and survivors. While focusing on difficult memories or feelings, the person is simultaneously tapping on acupoints that purportedly reduce arousal. In addition to processing the recent event, McAninch notes that, with the accidental deaths and injuries handled by his team, unresolved traumas from a survivor's past are often activated. Treating these, again by stimulating acupoints while the memory is actively engaged, helps the present traumatic incident, in McAninch's experience, to be more easily and rapidly resolved (J. McAninch, personal communication, May 5, 2007).

This use of a readily available technique that quickly decreases arousal is a critical difference between EP and debriefing or other interventions that might ask a person to recount a trauma within days after it occurred. Sophia Cayer, an EFT practitioner who worked with hurricane evacuees in Alabama following Hurricane Katrina explains: "The difference is that with EFT, even if it is only a single session, it doesn't leave the person stranded. It is not a matter of just soothing them and then letting them go. They are given powerful tools they can regularly use as they move through the crisis and beyond" (S. Cayer, personal communication, December 1, 2005).

For instance, Barbara Smith, a trauma specialist who works for a government-funded agency in New Zealand, often takes the official report of a person who has been recently traumatized (Carrington, 2005). She needs the people she interviews to recall and recount their traumatic experiences in detail to complete the necessary paperwork. Since some of them are still in deep shock from the recent incident or from earlier trauma that has been reactivated, and many reexperience the horror and overwhelm of the traumatic event in talking about it, it may take up to four sessions to complete a single report. And even then, the reports might not always be clear or coherent. By simply introducing tapping and having her clients continuously tap specific acupoints while recounting their painful experiences, Smith has found that "the time it takes to collect the crucial information is more than cut in half [and] the reports themselves are more coherent and accurate." She adds that as a side benefit, these trauma victims "learn how to calm themselves from the very first session" (Carrington, 2005).

Smith's use of EP is consistent with the way other practitioners report applying it within the first days or weeks following a trauma. While aggressive probing or invasive uncovering techniques are generally not used by EP practitioners immediately following a disaster, EP is often applied to memories and thoughts the client is already expressing or actively ruminating upon. Rather than utilizing a complete EP protocol, the tapping techniques that are most effective for reducing arousal are taught on a psychological first aid basis (first tier—immediate relief/stabilization, p. 2).

These techniques can be introduced in a simple and matter-of-fact manner. Young (2006, p. 143) provides a 30-second approach for introducing diaphragmatic breathing, gently using words such as: “Everyone feels overwhelmed now, how about we take a few slow deep breaths” [along with a demonstration of diaphragmatic breathing]. This could be followed by suggesting, “Let’s add to this now some tapping on stress release points. Just tap where I tap” (first tier--immediate relief/stabilization). Intrusive images, previous memories activated by the trauma, and the affect produced by cognitive distortions may also be the focus while points that reduce arousal are tapped (second tier—extinguishing conditioned responses, p.3).

Still valid, of course, are concerns about retraumatizing a disaster survivor who is beginning to stabilize, about undermining the individual’s natural coping strategies, and about inducing the person to process the trauma prematurely when a period of denial would allow the person to rest and regroup. As with any other early mental health intervention, sensitive clinical judgment and an awareness of the known counterintuitive outcomes of well-meaning early responses are critical ingredients for an effective intervention.

Demonstrating how to self-stimulate acupoints that reduce arousal provides a straightforward tool for emotional self-management that, according to EP practitioner reports, is quick, effective, and generally as safe as other relaxation techniques (Young, 2006, points out that in rare cases, any form of relaxation technique may increase anxiety, intrusive images, or dissociative states). Because tapping acupoints, when properly introduced and applied, is relatively noninvasive, even if it does not produce the desired effects, no harm is done by the physical procedure as such. Summarizing his experiences as a member of the TFT Trauma Relief Committee providing post-disaster EP services in Kosovo, Rwanda, the Congo, and New Orleans, Paul Oas observed: “Safety, food, and shelter come before emotional healing, but even under dire circumstances, you can use the tapping procedures to calm people who are hysterical” (P. Oas, personal communication, November 20, 2005).

Interventions One to Four Weeks after Exposure to a Trauma. After the initial phase of shock and disorientation, mental health interventions between one and four weeks following the disaster have different goals “and employ different strategies than responses that typically occur in the initial days after trauma exposure” (Bryant & Litz, 2006). While managing stress reactions is still a prominent concern, focus shifts to identifying individuals who are at greatest risk of chronic mental health problems and deciding how to use inevitably scarce mental health resources most effectively.

It may not be possible to make accurate distinctions about which survivors are vulnerable to chronic mental health disorders within the first week after a disaster. Even in the first month, symptoms of Acute Stress Disorder (ASD) have not proven accurate indicators of vulnerability to longterm PTSD. ASD was introduced into the *DSM IV* (American Psychiatric Association, 2000) to account for symptoms such as pronounced anxiety or arousal, intrusive thoughts or flashbacks, acute dissociation, marked avoidance, and other sequela to trauma that may occur two days to four weeks following exposure to an extreme stressor (the same symptom cluster meets the criteria for PTSD if it persists for more than a month). While meeting the criteria for ASD is a sign of high risk for PTSD, ASD symptoms become a better predictor if dissociative reactions are excluded from the criteria—people who meet all the criteria except dissociative symptoms are still highly vulnerable (Bryant & Litz, 2006). Other signs of vulnerability soon after the traumatic event include depression, catastrophic appraisals, functional impairment, and dissociative reactions with or without other ASD symptoms.

Also somewhat complex to interpret is the data on when to offer intensive treatment. Four sessions of CBT were provided to 10 female victims of sexual and nonsexual assault shortly after the assault (usually within two weeks) and outcomes were compared with matched subjects who received repeated assessments (Foa, Heast-Ikeda, & Perry, 1995). Two months following the assault, 70 percent of the assessment group met criteria for PTSD while only 10 percent of the CBT group met those criteria. At five months, however, there were no differences between the groups in the PTSD rates, suggesting that CBT accelerated recovery relative to natural remission, but did not prevent longterm PTSD. A subsequent study by the same lead author, which corrected for some design flaws in the original study, came to the same conclusion. Initial accelerated improvement was found in CBT participants compared with participants who received supportive counseling or assessment only, but by nine months all three groups showed similar PTSD rates (Foa, Zoellner, & Feeny, 2006).

Other studies of trauma survivors, however (reviewed by Bryant & Litz, 2006), suggest that 4 to 6 two-hour sessions of CBT applied two to four weeks following a trauma greatly reduces subsequent incidence of PTSD (e.g., in one well-designed investigation, 67 percent of a supportive counseling control group met the diagnostic criteria for PTSD at six-month followup compared to only 20 percent in the CBT group). Bryant and Litz caution, however, that “there is no research on CBT in the context of mass violence” (2006, p. 167). They also note that if it is not possible to apply CBT within the first few weeks of a trauma due to limited clinical resources or excessive demands on the trauma survivor, therapy for PTSD is still likely to be effective at a later point. Active psychotherapy during the first few weeks following a trauma, particularly approaches that utilize exposure treatments, may, in fact, not be indicated for individuals who were highly anxious prior to the trauma or for those exhibiting severe dissociative reactions, severe substance abuse or dependence, severe ongoing stressors, unresolved prior trauma, or significant suicide threat (Bryant & Litz, 2006).

EP treatments in the weeks following a trauma can continue to focus on lowering anxiety levels, countering intrusive thoughts and images, reducing arousal to previous memories activated by the trauma, and addressing the affect that induces cognitive distortions (second tier, extinguishing conditioned responses, p. 3). While a single EP session is, according to practitioner reports, often effective for work at this level, the option of appropriate follow-up or referral should be insured with individuals showing signs of vulnerability to chronic PTSD or other psychological disorders.

A reported strength of EP in reducing symptoms of acute stress is that it can be efficiently taught as a self-soothing technique in group settings. Participants are also able to experience immediate relief without, as contrasted with debriefing, having to reveal to other group members specific memories or emotions. In one variation, the practitioner works with a volunteer in front of the group. At the same time, the group is instructed to self-apply some of the procedures being used with the volunteer, focusing on the volunteer’s psychological distress rather than on their own. A reduction in the emotional intensity of issues audience members had previously identified is subsequently reported by a large proportion of the group.

While no studies have been conducted on the use of this technique in post-disaster situations, there is some evidence for its efficacy with a general population. A within-subjects design was used with 102 participants who attended either of two 3-day EFT workshops open to the general public (Rowe, 2005). The participants were given a well-established, standardized symptom checklist (the Derogatis Symptom Checklist, short form) one month prior to the

workshop, immediately prior, immediately after, one month after, and six months after the workshop. No significant difference was found in the mean test scores one month prior to and immediately prior to the workshop. Following the workshop, a highly significant decrease ($p < .0005$) was found on the checklist's global measure of psychological distress as well as all nine subscales, and these improvements held at the six-month follow-up. While the mechanisms for such outcomes are still unknown, practitioners are consistently describing this finding, and reported applications following disasters seem encouraging.

For instance, about a month following Hurricane Katrina, Roseanna Ellis, an EFT practitioner, and three of her colleagues were asked by the pastor of a small church in Selma, Alabama, to work with his congregation, which was hosting a number of displaced hurricane survivors. Prior to extending this invitation, the pastor had experienced marked relief from symptoms of compassion fatigue as well as from some longstanding personal challenges during a single EFT session with Ellis.

The church held a Wednesday evening "family night" and Ellis and her team were invited to attend it to introduce EFT. Of 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. Each demonstration subject was treated for between ten and twenty minutes.

A 52-year-old woman, for instance, who had been forced from her home, tearfully made each of the following statements and rated each as a 10 on the 10-point SUD 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 appeared calm and in control, 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, "Bring 'em on baby, bring 'em on!"

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, initially at a SUD level 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, the audience commented on the way he walked off the stage with substantially greater speed and ease than the way he walked onto it.

Before the stage work with these individuals, each audience member identified a personal area of emotional distress and rated it from 0 to 10. They then put their own issues aside as the

demonstrations were conducted. But with each person on the stage, the audience self-applied the same procedures being used by the person on the stage. If the person on stage was tapping a set of acupoints while stating, “feeling displaced,” the audience was doing the exact same tapping and making the exact same statement. Known as “Borrowing Benefits” (Rowe, 2005), this method is repeatedly reported to bring down the distress level for the original issue identified by a vast majority of audience members, even if there is no treatment that focuses specifically on the personal issues the audience members had selected earlier. 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. Describing the value of using this approach with a group of people who have shared the same trauma, Ellis notes that “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” (R. Ellis, personal communication, December 2, 2005).

While this is a method that warrants investigation, its parallels with debriefing need to be carefully weighed. The merits of debriefing may have been contaminated when, after its initial popularity, it began being applied to populations for which it was not designed and by practitioners whose mental health backgrounds and training were far more limited than that of those who originated the approach. EP practitioners can learn from this history. Among the guidelines that are emerging for using EP with groups are that it be made explicit that audience use of the tapping is voluntary, that audience members be instructed not to focus on an issue that is overwhelming, that there is no expectation that audience members will share the issue on which they are focusing, and that any participant whose distress level is not reduced or is increased during the group tapping be provided follow-up with the practitioner during the group meeting or soon after it.

In providing mental health interventions with disaster survivors, demographic considerations are pertinent (Norris & Alg eria, 2006). While little empirical evidence exists based solely on work with disaster survivors to guide practitioners in establishing differential treatments for specific populations, the general principles for any clinical work with ethnic and cultural groups different from that of the practitioners’ apply. For instance, in cultures where there are restraints on men about expressing emotional distress, it may be challenging to name the specific issues that need to be mentally activated during the tapping. Carl Johnson points out, in fact, that treatment success can sometimes “hang on the use of a culturally or personally-sensitive word” (personal communication, September 30, 2005):

An ethnic Albanian who spoke English brought a former Kosovo Liberation Army soldier to my hotel. The translator said, “He’s here for help with his war trauma.” I explained the 0 to 10 scale and asked him to give me a number for the intensity of his trauma. The translator conferred with the man and then said, “No number, none.” I asked, “Isn’t he here because he is suffering from trauma?” The translator restated, “No number, no trauma.”

I sensed that while the man had come for help, he was also obeying the Albanian taboo which forbids suffering in males. I decided to bypass any mention of his suffering and said to the translator, “Okay, but could you ask him to just think about the traumatic event.” The response: “No traumatic event.” It dawned on me that by definition, to qualify as a traumatic event, it would have had to cause a personal trauma, which he couldn’t admit to. So I asked if he had had a

challenging experience, a bad moment that he had overcome.” To this, he could say “Yes.” So I had him think about the bad moment he had overcome. I asked him if he would enjoy having a tune-up on his strong body to get it ready for his next victory, like tuning up the engine of a magnificent race car that has won but needs to have a tune-up to win again.” He said, “That would be fine.” As he focused on the event he had overcome, I used TFT diagnostics to find and treat his energy disruptions. Finally when I could find no further disruptions in his energy system, I asked him if anything more had to be done or if the tune-up had been complete. He looked relaxed. Then he spoke through the translator: “He wants me to tell you he thanks you very much for healing his trauma.” Once the trauma had been resolved, it was no longer an issue for him to use the word.

Many variations of this issue may be encountered by relief teams deployed to other cultures. Even explaining EP in terms that are respectful of and congruent with the person’s worldview and assumptions about healing may be problematic. Explaining an approach that is rooted in a paradigm adopted from traditional Chinese medicine has, in fact, proven to be a substantial challenge for Western EP practitioners within their own culture. The use of EP with children also requires calibration. Children respond at least as well as adults to tapping for reducing arousal, according to practitioner reports, but the approach must be framed at a level that is appropriate to the child’s age, situation, and level of understanding.

Interventions after the First Month. Raphael and Wooding (2006) describe a “honeymoon period” shortly after a disaster, during which there is intense affiliative behavior, convergence of support, and public acknowledgement of heroism and suffering.” This phase may, however, over time “merge into angry protest and disillusionment and demoralization, then progressive recovery and renewal” (p. 175). By a month following the disaster, “the impact of loss of human life, injury, and destruction of physical and social resources should be fairly clearly defined” (p. 177). Individuals who may be in need of longer-term treatment can be identified. Particularly vulnerable are those who are bereaved, injured, whose acute stress symptoms persist, who were most severely exposed to the disaster, whose physical and social resources have been destroyed, who have been previously traumatized, who had preexisting mental illness or physical disabilities, and who served as emergency responders.

Various studies cited in Ritchie, Watson, and Friedman (2006) suggest that CBT is the most effective available treatment for PTSD, with psychoeducation, cognitive restructuring, exposure, and anxiety management techniques such as relaxation training being the components most frequently utilized. In a study that attempted to identify the essential components of CBT, prolonged exposure and cognitive therapy were as effective in preventing PTSD as prolonged exposure and cognitive therapy *plus* anxiety management. Forty-five civilian trauma survivors exhibiting symptoms of ASD were randomly assigned to the two experimental groups or to a supportive counseling control group. At six month follow-up, about one-fifth of those in each experimental group had PTSD, compared with two-thirds in the supportive counseling group. Treatment gains from both experimental groups held on four-year followup (Bryant, Moulds, and Nixon, 2003).

As with CBT, EP utilizes cognitive restructuring in conjunction with its exposure methods. Mollon, in fact, asserts that EP is not an *alternative* to CBT, but a “crucial additional component that greatly enhances its efficacy,” providing more effective means for “affect regulation, desensitisation, and pattern disruption” (2008, p. 619). Pessimistic appraisals,

avoidance strategies, and self-limiting beliefs about self, world, and future—all common consequences of traumatic events—are amenable to restructuring when the affect triggered by traumatic memories and anticipated analogous situations is significantly reduced. In addition, a tapping protocol for “neutralizing negative core beliefs and for instilling positive ones” (Gallo, 2004, p. 181) has been found effective by EP practitioners. Whether focusing on a traumatic memory that is tied to maladaptive cognitions or addressing a belief that contributes to pessimism and hopelessness, reducing hyperarousal and cognitive restructuring are natural counterparts of an EP approach.

Those who worked with the Kosovo, Rwanda, Congo, and South Africa survivors described in Table 1 assert that decreasing arousal to the most horrific memories of civilian survivors of warfare and ethnic cleansing produced global improvements in the person’s ability to function. While the only systematic outcome information available from these interventions is based on the impressions of the physicians who continued to medically care for approximately three-fourths of the first 105 people to receive TFT in Kosovo, plus the informal investigation by Kosovo’s chief medical officer, these assessments are encouraging. Asked how he determines if a treatment for a traumatic event has been successful, Carl Johnson replied: “It has been successful when there is no suffering or anguish upon recalling the event. But at the same time, there is no reduction in sensitivity, distortion of values, or impairment in the ability to love. The memory is retained, but it is no longer in neon. There is still an awareness of the horror of the event, but it no longer has its grip on the person’s soul. Where the memory had controlled the person, now the person has control of the memory.”

Other reports of brief EP treatments following dire events corroborate the viability of a strategy whose focus is to rapidly reduce the hyperarousal associated with traumatic memories, disturbing ruminations, and negative appraisals. For instance, a team of twelve TFT practitioners from eight states was invited by three medical and social service organizations in New Orleans to provide treatment and training to their staffs four months following Hurricane Katrina (H. Ayers, personal communication, January 30, 2006). These medical and social service personnel were inevitably victims of the disaster as well as helpers, and the strategy taken was to make their treatment part of their training. A total of 161 participants received treatment and training at six different sites, with the largest number in an army tent at the Charity Hospital’s “MASH unit” in the New Orleans Convention Center. 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 Caroline Sakai on the 22 participants she treated showed that their presenting complaints included anger, anxiety, depression, eating in order not to feel, frustration, guilt, 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 given a 0 to 10 SUD rating. Before treatment, the average (mean) score for the 51 problem areas described by the 22 clients was 8.14. After treatment, usually consisting of a single individual session of under 15 minutes (which followed a half-hour group orientation), it was down to 0.76.

Longterm treatment of PTSD and other psychological damage following disaster experiences typically involves more than healing traumatic memories, reducing hyperarousal, and transforming negative beliefs. Lifelong psychological and behavioral patterns may be examined, relationships may be transformed, and social involvements may radically shift during the reorientation process that follows the destabilization caused by severe trauma. The term

“post-traumatic growth” has been coined to describe the greater resilience and higher level of functioning that ideally is an outcome of traumatic experiences. A study of the longterm impact of the most traumatic life experiences of 83 “elders” (average age of 77.9) suggested that “post-traumatic growth from events that occurred even many years earlier may have favorable influences on subsequent coping, death attitudes, and adjustment to recent stressors” (Park, Mills-Baxter, & Fenster, 2005, p. 297). While post-traumatic growth appears to be a natural adaptation that frequently occurs, the clinician’s awareness of this organic tendency can help in supporting it.

EP may be combined with additional components of CBT as well as with methods from depth psychotherapy (Mollon, 2008) in addressing the demanding psychological challenges many people face following a severe traumatic experience (third tier—overcoming complex psychological problems, p. 3). In addition, methods that enhance confidence, optimism, courage, performance, social skills, and feelings of spiritual connectedness (fourth tier—promoting optimal functioning, p. 3) are often useful at this time. Larger existential questions may also need to be addressed, such as “Why did I survive?” when loved ones or others were lost. As Shalev (2006) noted, most therapies tackle negativity rather than to explicitly foster positive emotions. But it is the desire for life that ultimately motivates survivors--whose shock, despair, and depression may be overwhelming--to recover: “We regularly address survivors’ negativism, hoping that once the grip of such emotions loosens, the desire for life will put the trauma back into its right place as interference with life rather than life-defeating occurrence” (p. 118).

Avoiding Inadvertent Harm

When a therapy team responds to a disaster, particularly if the team is traveling to a culture with which it has little familiarity, the challenges of successfully delivering its clinical skills are embedded in language barriers and cultural differences, along with the tendency of the therapy team to unwittingly project its own social values, mores, and assumptions onto the situation. These challenges extend to the accurate assessment of needs and outcomes. Even an approach as widely endorsed by the professional community as Critical Incident Stress Debriefing had competent, caring therapists leaving unrecognized harm in their wakes. And CBT, whose efficacy is established for treating and preventing PTSD following traumatic events, has received little investigation following disasters in conditions that are markedly different from those in which CBT evolved.

Nor does outcome research on EP establish its safety in treating disaster victims. Preliminary indications about potential harm are, however, available. At the most basic level, no incidents where harm was done were identified, in response to direct questioning, during the inquiries conducted for this paper with the members and leadership of the three major organizations (the Green Cross, the TFT Trauma Relief Committee, and the ACEP Humanitarian Committee) utilizing EP interventions in disaster areas.

In each case that a team went into a disaster area, beyond the team’s own case reports and outcome evaluations, local observers in positions of authority offered—whether formally or informally—strikingly positive post-deployment assessments, most often with invitations or appeals for return visits. Pierre Ilunga, the director of the El Shaddai Orphanage in Rwanda (he also serves as a university professor and holds a Ph.D. in geology), in a letter to the TFT Trauma Relief Committee members who worked with the orphanage, noted simply “Our life has been

changed in a better way” in requesting a return visit. Local follow-up, such as by the physicians who stayed in contact with approximately three-fourth of the first 105 individuals treated in Kosovo, has consistently indicated, according to spokespersons for the Green Cross, the TFT Team, and the ACEP Team, that the benefits of the treatment are lasting and the treatment did not result in reports that would lead to concerns about unintended harm.

Often, in fact, the communications from local observers indicated surprise and appreciation that the EP interventions were so unexpectedly superior to other approaches. These sentiments are evident, for instance, in the letter cited earlier from the chief medical officer of Kosovo and the following, from a letter expressing appreciation and an invitation to return, written by Dwayne Thomas, M.D., Chief Executive Officer of the Medical Center of Louisiana at New Orleans. The letter, which was sent to members of the TFT Trauma Relief Committee about a month after their first visit to New Orleans following Katrina, mentions other treatments that had been used by the hospital and then observes: “The overwhelmingly positive response to the [TFT] therapy was a welcome and delightful surprise for us all.”

Conclusions

Strong anecdotal reports about the efficacy of EP have been accumulating for more than twenty years from a spectrum of credible sources, and a growing number of controlled comparison studies are promising (Feinstein, in press). Increasing numbers of psychotherapists have been applying EP in emergency and post-disaster settings and reporting that it appears to be an effective tool for rapidly reducing hyperarousal, for stress management, and for overcoming a wide range of affect-related disorders. It also integrates well into other protocols, such as CBT, for longterm healing of those who are most seriously damaged by their experiences during a disaster. While we are still learning about the power, limitations, and best applications of the approach, the purported ability of EP to rapidly reorganize the emotional and behavioral disruption that occurs for many people in the aftermath of severe trauma establishes it as a potential resource worthy of serious attention by those charged with the care of disaster survivors.

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