Short communication
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Energy for treating trauma/PTSD

Abstract

Traditional treatments for trauma and PTSD are often ineffective or take extensive time to relieve trauma/PTSD. However, newer methods, such as energy psychology, are showing promise in providing rapid and lasting relief. Energy psychology is based on the concept of subtle energies in the body that can be utilized to heal trauma. Most energy psychology methods involve tapping on specific acupoints while attuning the traumatic memory. Many studies suggest that energy psychology is a promising new treatment for trauma and PTSD, in addition to several other psychological problems. It is a safe and effective way to reduce symptoms and improve quality of life. The case study in the article describes how energy psychology was used to help a young woman who was suffering from PTSD after a car accident. In just one session, the woman's symptoms were significantly reduced, and she was able to recall the traumatic event without distress. This case study provides further evidence of the effectiveness of energy psychology in treating trauma and PTSD. In addition to subtle energies, the article also discusses other feasible active ingredients of this approach, including reciprocal inhibition, expectation of success, and pattern interruption and disruption.

Keywords: psychology, emotional numbing, traumas, broken ankles

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Introduction

Many standard treatments for trauma, posttraumatic stress disorder (PTSD), and phobias are being supplanted by or integrated with newer methods based on different assumptions. These therapies often produce trauma relief within a single session, alleviating intrusive thoughts, flashbacks, anxiety, panic attacks, depression, guilt feelings, emotional numbing, and dissociation. Simultaneous stimulation or dual focus of attention is an obvious factor in these therapies. In *eye movement desensitization and reprocessing* (EMDR) the client reviews the traumatic memory while engaging in bilateral patterns of eye movement and other forms of bilateral stimulation.[1] With *visual/kinesthetic dissociation* (V/KD) the client reviews the trauma from a position of therapeutic dissociation— "Watch you watching yourself going through that trauma way over there in the past"[2] *Traumatic incident reduction* (TIR) engages the client in back-and-forth viewing and then talking about the trauma in detail until the missing pieces of the puzzle are assembled.[3] And many *energy psychology* (EP) approaches such as *thought field therapy* (TFT) and *emotional freedom techniques* (EFT) similarly directs the client to think about or attune the trauma while tapping a sequence of acupuncture meridian points or acupoints.[4–9]

Since the 1995 demonstration project of these *power therapies* by Charles Figley and Joyce Carbonell at Florida State University,[10] other approaches have been developed that employ similar yet innovative strategies. I developed *energy diagnostic and treatment methods* (EDxTM), which includes an easily applied global treatment—the *Midline Technique (MLT)*)[1]—that can be used for trauma/PTSD, phobias, anxiety, and other psychological conditions. EDxTM and MLT are examples of what I coined as *energy psychology*, which includes *TFT, EFT,* and a number of related energy-based methods. These approaches are based on the assumption that there exist subtle energies in the body that serve as a control system for emotions as well as health in general. (For detailed coverage of these innovations, see my edited volume *Energy psychology in psychotherapy: A comprehensive source book.*

There are many active ingredients that account for the effectiveness and efficiency the power therapies, although here I will focus on energy psychology. In addition to dual focus of attention, similar to Joseph Wolpe's counter conditioning technique—*systematic desensitization*—I believe that reciprocal inhibition is a factor. In systematic desensitization, clients are taught to deeply relax and then imagine increasingly distressing images related to their phobia. The idea here is that you can't relax and be anxious or distressed at the same time. Energy psychology produces relief much faster than traditional counter conditioning techniques. By tapping on certain acupoints while thinking about the traumatic event, it becomes difficult to lose yourself in the trauma, and therefore you are unlikely to become distressed. Similar effects are achieved by stimulating the Bennett neurovascular reflexes on the head or the *Marma* (vital points) of Yoga.

In addition to reciprocal inhibition, I believe that other active ingredients include the degree of rapport between therapist and client; maintaining orientation to present time, rather than becoming emotionally submerged into the traumatic memory; expectations of immediate positive results; paradoxical intention; pattern interruption and disruption; interrupting the limbic system's stress response associated with the memory; activating subtle energies; and directly targeting or attuning the memory and negative emotions. Although abreaction is considered to be favorable according to some therapies, exposure to the point of emotional flooding is unnecessary from the standpoint of energy psychology. If one of the most fundamental aspects of the trauma is the subtle energetic substrate that triggers the chain of events that maintain the trauma, then only the subtlest degree of tuning the trauma is needed, as the following case illustrates.

The case of Amanda

Amanda was an attractive 19-year-old female college student who was brought to me by her mother because of PTSD as a result of a severe automobile accident. The intoxicated driver of the other vehicle crossed over the medial strip and struck Amanda's car head-on, unfortunately killing himself and his two passengers. Amanda was pinned under the dashboard for over three hours while a rescue team applied the Jaws of Life and cut her out of her car. She was then life

[1]Previously called negative affect erasing method (NAEM), the current version involves 6 treatment points: occiput, crown of head, third eye, under nose, under bottom lip, thymus point on chest.

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flighted to a hospital and later spent several months in a rehabilitation center and in a wheel chair. She suffered broken ankles, a broken arm and shoulder, back injuries, and facial lacerations. When she came to me eleven months after the accident, she had been experiencing frequent nightmares, flashbacks, panic episodes, generalized anxiety, guilt feelings and anger related to the traumatic event.

Amanda and her mother participated throughout the initial session, at which time intake and detailed history were obtained. During that time, we also had some light-hearted talk and developed rapport. Toward the end of this first session, I told Amanda that I had some ways to help people overcome painful memories that often worked quickly and painlessly. I indicated that I didn't know if this would help—since we only had about ten minutes left in the session—but at the very least I wanted to introduction her to the kind of work we would be doing in future sessions.

I asked her to bring to mind an aspect of the accident that still bothered her. She chose to focus on the time when she was pinned under the dashboard and she rated her subjective units of distress (SUD) on a zero-to-ten scale as a nine at the time of our session. I then asked her to imitate me as I tapped with my fingers at specific locations on my body. Also, rather than asking Amanda to hold the traumatic memory in mind and risk abreaction, I asked to dismiss it from her mind and to assume a specific body posture called a *leg lock* or *pause lock* in order to maintain the bioenergetic information about the trauma at a subtle, more comfortable level during the treatment process. The leg lock involves standing or sitting with legs abducted—similar to the second position in ballet—after the trauma has been brought to mind and rated. Although this and other locking procedure have many advantages, frequently they are unnecessary since the trauma tends to resonate at a subtle level—like the lingering vibration of a tuning fork—after it has been brought to mind.

We then went through the MLT protocol, intermittently reassessing the SUD level. MLT includes tapping, rubbing, or pressure touching several times at four locations—on the forehead above the nose, also called the *third eye point*; under the nose; under the bottom lip; and at the upper section of the chest bone, also called the *thymus* point since this is the location of the thymus gland. (At times we add two additional points on the governing vessel: occiput at back of head, and top of head.)

After one round of MLT, I asked Amanda not to bring the trauma to mind but to simply guess what the level of distress would be if she were to recall it vividly. At this point she said that she did not think it would be different. "Still a nine," she said. I told her that was fine and that we should give this another try. Again, I guided her through MLT: third eye point, under nose, under bottom lip, thymus point, after which I asked her to estimate the level of distress if she were to think about the event. This time she said, "I feel more relaxed. I think it might be a six."

Next, I took her though the *brain balancing procedure* by having her follow my fingers in a horizontal 8 across her line of vision while she tapped on the far ends of her eyebrows near her temples and alternated counting to five and humming the scale. After this she estimated that the SUD would be a three if she were to really think about the event vividly.

After two more rounds of MLT followed by a vertical eye movement technique combined with tapping on the back of her hand between and above the little finger and ring finger knuckles, Amanda said that she did not think it would bother her if she were to "really" think about being pinned under the dash board. So, I asked her to check it out. After reviewing the scene for a couple seconds, she laughed and enthusiastically responded, "Wow! It doesn't bother me now! How does that work?"

I told her that while I would be happy to explain this to her, I wasn't sure she had given this a fair test yet. So, I asked her to review the memory in more detail to be sure that it did not bother her. After about ten seconds she shook her head, laughed, and reported that it still didn't bother her.

Next, I asked Amanda to do one more test. I set a timer for one minute and asked her to try to bother herself about the memory while her mother and I talked over a few things. I pointed out that if she could feel distress about any aspect of the event that would mean that we needed to do some more treatment on that memory. To really test it out, I asked her to picture the event as it was—the way her body was positioned in the car, the front seat cramping her in, sounds of the rescue workers cutting her out of the car, and so on. To no avail Amanda tried her hardest to become upset about this vivid memory. She was able to review the event calmly in detail. Her comment was, "It's amazing! No big deal now! How does that work?" At this point I told her why I thought this worked and we and reviewed how she could repeat the treatment if it became necessary between sessions.

Follow-up sessions at one week, two weeks, and two months revealed that after that initial treatment, Amanda no longer experienced nightmares and flashbacks about that trauma. During the course of therapy, other aspects of the trauma, including survivor guilt and anger, were treated in a similar manner. These issues were also relieved efficiently by using either MLT or, when necessary, an energy diagnostic and treatment methods (EDxTM) protocol that involves manual muscle testing to precisely diagnose acupoints needed to relieve distress.

During the initial session Amanda revealed that from ages five through twelve, a relative molested her when she was a child. After successfully treating all of the aspects of the vehicular trauma, we treated several of her distressing memories of being molested. These traumas were readily resolved in similar ways, without having to intensely think about the events. Even after treating the traumatic memories that she was conscious of, she reported a lingering feeling of being "dirty and disgusting," which was localized in the vicinity of the lower abdomen. Although she could not attach specific memories to this feeling, she said that this made her feel that she was not worthwhile. With energy psychology we were able to dissipate this sensation permanently in a single session and her sense of not being worthy vanished with it.

Reflections on energy psychology treatment

I realize the limitations of anecdotal reports and that experimental studies are needed before energy psychology will be accepted by the scientific and therapeutic communities. Insufficient compared to the vast number of experimental studies on cognitive behavioral therapy; however, to date 99% of 155 studies have demonstrated the effectiveness of EP, over 80 being randomized controlled trials, and 75+ clinical outcome studies (see the ACEP Website at energypsych.org). Additionally, so far five meta-analyses have been published that reveal one moderate and 4 strong effects.[11–16] Nevertheless, these treatment results have become quite common and we should not forget that experimental studies are actually anecdotal reports systematically gathered according to statistical guidelines to control for other variables and in order to generalize to the wider population. Also, my colleagues and I have similarly treated thousands of clients suffering from intense traumas. The results are generally achieved

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efficiently and without the client having to experience distress during the process. You might say that therapist enthusiasm is another active ingredient, to which we should extend a hearty welcome. However, I've never found enthusiasm to be the sufficient condition for therapeutic success.[17,18]

How will these results ultimately be explained? As it is often said, "The jury is still out." As one of the jurors, I believe that energy psychology does exactly what the name implies. While psychological problems can be viewed cognitively, neurologically, chemically, and behaviorally, they are also energetic. Our bodies and nervous systems operate electrically and electromagnetically at both profound and subtle levels. This is even the basis of medical technologies such as electroencephalography (EEG), electrocardiography (EKG), magnetic resonance imaging (MRI), etc. Fundamentally, everything is energy, with matter being congealed energy. A traumatic experience includes a strong electromagnetic charge that is captured by the nervous system in a stable form—also called in-formation—in the same way that pebbles tossed into a pond would leave an ongoing record if the pond could freeze instantly upon impact. By attuning the trauma and activating subtle energy systems, the stored information is released. Energy psychology essentially thaws the pond.[19,20]

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None.

Conflicts of interest

There is no conflicts of interest.

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