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Efficient treatments for trauma/PTSD: harnessing the power of bioenergy to efficiently treat psychological distress

Abstract

Energy Psychology includes a variety of bioenergy methods that can efficiently alleviate trauma and Posttraumatic Stress Disorder. This article reviews several of those approaches, with emphasis on one of the author's methods and offers analysis of the active ingredients of these treatment approaches.

Keywords: Energy Psychology (EP), Energy Therapy, Thought Field Therapy (TFT), Emotional Freedom Techniques (EFT), MidLine Technique (MLT), Trauma, PTSD, Energy Diagnostic and Treatment Methods (EDxTM)

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Introduction

Many treatments for trauma/PTSD involve exposure and cognitive restructuring, in addition to psychopharmacology. Further, for the most part, PTSD has been considered to be incurable and only manageable. However, some relatively newer approaches often produce trauma relief and possibly cure within a few sessions, resolving the various posttraumatic symptoms, including startle response, intrusive thoughts, flashbacks, emotional numbing, and dissociation. Engaging the body in the treatment is often a fundamental feature of such approaches, rather than conceptualizing the mind and body as separate. Simultaneous stimulation or dual focus of attention is also an important aspect of these treatment approaches. For example, eye movement desensitization and reprocessing (EMDR) guides the client to review the trauma while engaging in bilateral patterns of eye movement, alternating sounds in ears, hand tapping, etc. Visual/kinesthetic dissociation (V/KD), a technique from Neurolinguistic Programming (NLP) involves trauma exposure from a position of therapeutic dis-association, directing the client to "Watch you watching yourself going through that trauma way over there in the past." And many energy psychologiesy (EP) approaches such as thought field therapy (TFT) and emotional freedom techniques (EFT) similarly directs the client to think about or attune the traumatic memory in digestible chunks while tapping a sequence of acupuncture meridian points or acupoints. Since the 1995 demonstration project of these power therapies by Charles Figley and Joyce Carbonell at Florida State University, other approaches have been developed that employ similar innovative strategies. I developed energy diagnostic and treatment methods (EDxTM), an Advanced Energy Psychology approach that includes a global treatment or algorithm—the Midline Technique (MLT))[1] that can be used for a variety of conditions, including trauma/PTSD. EDxTM and MLT are examples of what I coined as energy psychology, which includes TFT, EFT, and some a number of energy-based methods. These approaches are based on the theory that there exist subtle energies that activate negative emotional states. (For detailed coverage of several of these innovations, see my edited volume Energy psychology in psychotherapy: A comprehensive source book.[1]

[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*

Many active ingredients there are many active ingredients that account for the effectiveness of the power therapies, although here I focus on energy psychology. In addition to the dual focus of attention, similar to Joseph Wolpe's counter conditioning technique—systematic desensitization—reciprocal inhibition is an important 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 cannot relax and be anxious or distressed at the same time. However, energy psychology produces relief much faster than traditional counter conditioning techniques. By tapping on specific acupoints while thinking about the traumatic event, it becomes difficult to lose yourself in the trauma, and therefore you are unlikely to become distressed. In addition to reciprocal inhibition, other active ingredients include the relative health of the client; the client's and therapist's intention and motivation to alleviate the trauma, belief in the treatment, positive expectations, and quality of rapport between therapist and client; orientation to present time while reviewing the past event (staying focused on "That was then, this is now.") interrupting the limbic system's stress response associated with the memory; and memory reconsolidation. Although abreaction has been considered to be favorable according to some therapies, this is unnecessary from the standpoint of energy psychology. Assuming that one of the most fundamental aspects of the trauma, or any chronic maladaptive emotional reaction, is the subtle energetic substrate that triggers the chain of events (energetic-neurologic, chemical, cognitive) that maintain the PTSD, then only the subtlest degree of tuning the trauma is needed, as the following case illustrates.

Amanda was an attractive 19-year-old female college student who had PTSD as a result of a severe automobile accident after a head-on collision with another vehicle. The other driver was intoxicated at the time, and the crash resulted in his and his passengers' deaths and Amanda being pinned under her dashboard for over three hours while a rescue team freed her from the car. She was then life- flighted to a hospital and afterwards spent several months in a rehabilitation center and in a wheel chair. When I saw her 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. I also focused on developing a rapport with her, which is also an

important aspect of stabilization and promoting security. Toward the end of this first session, I told Amanda that I had some techniques that often help people resolve trauma quickly and painlessly. I said that I didn't know if this would help her at the moment, since we only had about ten minutes left in the session. However, I wanted to get a sense of the kind of work we would be doing in future sessions. Therefore, I asked her to think about an aspect, a scene of the accident that still bothered her. She focused on being 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 memory in mind, I asked to dismiss it from her mind and put it in a kind of container. 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.[2]

After one round of MLT, I asked her 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 the MLT tapping points, after which I asked her to estimate the level of distress. This time she said, "I feel more relaxed. I think it might be a six." Next, I took her though a brain balancing procedure by having her follow my fingers in a horizontal eight8 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 of 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 upset herself about the memory while her mother and I talked over a few things. I pointed out that if she could feel distressed 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. Amanda tried her hardest to become upset about this vivid memory, but she was pleasantly unsuccessful. 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 reviewed how she could repeat the treatment if necessary before our next session. Follow-up sessions at one week, two weeks, and two months revealed that after that initial treatment, Amanda no longer experienced trauma symptoms. During the course of therapy, various aspects of the trauma, including survivor guilt and anger, were treated similarly in a similar manner. These issues were also relieved efficiently by using either MLT or, when necessary, and XEDxTM protocol that involves manual muscle testing to more precisely diagnose acupoints needed to relieve distress. During the initial session Amanda revealed that from ages five through twelve, a relative molested her. After successfully treating all of the aspects of the vehicular trauma, we treated several of her 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. In its place we also reinforced the positive sense of being worthwhile by holding that thought in mind while she tapped at specific points.

[2]Additional MLT points include the occipital region back of the head, and the top of the head, both of these being locations on the Governing Vessel.

Reflections

As rewarding and relevant as anecdotal reports are, experimental studies are needed for energy psychology to be accepted by the scientific and therapeutic communities. Therefore, to date over 100 studies have been conducted on the effectiveness of EP, over half were being randomized controlled trials.[2] Additionally, so far five meta-analyses have been published that reveal moderate to mostly strong.[3–7] Also, my colleagues and I have similarly treated thousands of clients suffering from intense traumas, PTSD, and other emotionally-charged disorders. The results are generally achieved 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. How will these results ultimately be explained? While psychological problems can be viewed cognitively, neurologically, chemically, and behaviorally, they are fundamentally 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, even our thoughts, and emotions. A traumatic experience includes a strong emotional, electromagnetic charge that is captured by the nervous system and the body as a whole—also called information—similarly to the way that pebbles tossed into a pond 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. The memory imprint is dissipated, or entropy is introduced, to borrow a term from physics. Then a new memory is formed, a memory of the event "way over there in the distant past" without distressing emotional charge. Energy psychology thaws the pond. Energy psychology offers the patient a new lease on life.[8–14]

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None.

Conflict of interest

The author has no conflicts of interests in this work.

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