INTEGRATING EP METHODS INTO CURRENT "BEST PRACTICES" OF TRAUMA TREATMENT

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When we discuss the use of Energy Psychology treatments for trauma, we tend to discuss them as an alternative – and even as being in opposition – to standard, conventionally accepted treatment protocols. Reflecting on this, it strikes me that engaging in this narrative of difference cultivates a sense of opposition - may actually contribute to some of the resistance we encounter – and it may be neither necessary nor appropriate. It is quite possible to present Energy Psychology techniques (more so than their broader theoretical underpinnings and implications) as fitting rather seamlessly into accepted practices.

So, what are the currently accepted "best practices" for treating trauma? Many practitioners don't realize that in the "conventional" or "mainstream" psychological world there is no clear consensus about best practices. In 2008, the International Society for Traumatic Stress Studies published the second edition of a book entitled Effective Treatments for PTSD: Practice Guidelines. The literature was reviewed on a variety of treatments for PTSD, and they were graded on a scale from A to E, according to the empirical support for their efficacy. As reported on the APA website http://www.apa.org/monitor/jan08/ptsd.aspx treatments given the "A" rating include: Prolonged-exposure therapy; cognitive processing therapy; stress inoculation training; other forms of cognitive therapy; EMDR; and medications.

In other words, the research that has been done to date suggests that there are a number of approaches that are more effective than other approaches, but within that literature there is no clear indication of one approach standing out as superior. It is also underlined in this book that there are weaknesses within the research – what is being researched, and how it is being researched – that preclude the possibility of drawing any overarching conclusions about "best practices".

> At present, few empirical data exist to guide us in the question of how to decide the course of treatment for PTSD.
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> ... There is an increased awareness among clinicians and researchers that the goals of treatment should include reduction of not only PTSD symptom severity but also associated symptoms, such as depression, general anxiety, anger, shame, and guilt, as well as improved quality of life.

The authors go on to say:

> The clinician is encouraged to adopt treatments that have been proven effective. However, it is important to remember that several treatments with proven efficacy are

> available. Also, *many treatments that have not been evaluated in well-controlled studies have been practiced extensively and have accumulated clinical evidence for their efficacy.* The distinction between clinical wisdom and scientific knowledge is emphasized here (my emphasis.)

So if we are discussing the integration of Energy Psychology into conventional treatment protocols, we need to keep this reality about the current, "conventional" expert opinion in mind. We are not engaging with – or in opposition to – a unified, monolithic idea or belief about the treatment of trauma; we are engaging in an area of the field that is full of diverse opinions and approaches, and that recognizes that the research shows that markedly different approaches are equally, or at least relatively, effective and useful. We are engaging in a discussion in which it is recognized that *clinical efficacy* should be considered in choosing a treatment approach, *with or without* conclusive research evidence.

Nevertheless, within this field that is characterized by the recognition of a multiplicity of approaches and a diversity of opinions, there is clearly some resistance to new additions to the discussion – as the EP field is actively experiencing today, and as was experienced some years ago by EMDR. So it is useful to look at the dominant, accepted beliefs regarding "best practices" in trauma treatment that might be resistant to Energy Psychology. Many practitioners do subscribe to the belief that the "best practices" in trauma treatment involve CBT and/or exposure and/or a stage approach. Therefore, to engage in a discussion about this, it may be useful to ask: to what degree are Energy Psychology modalities compatible with these treatment approaches and others that are generally seen as being validated by the research literature?

<u>Stage Approach</u>

The idea of stages in trauma treatment permeates or at least informs many approaches, and is perhaps the most productive way to begin looking at integrating Energy Psychology techniques and methods into conventional approaches. There are some variations on the formulation of these stages, but they all essentially correspond to what Turner, McFarlane and van der Kolk (1996) have described as the "three functions of trauma treatment": the focus of the first function/stage is "stabilization – controlling and mastering physiological and biological stress reactions". The focus of the second function/stage is "helping the individual come to terms with the horrifying, overwhelming experience ... beyond the person simply remembering and reporting the verbal schemata. Treatment must address the somatosensory, emotional, and biological, as well as the cognitive, dimension of experience." The focus of the third function/stage is "helping the individual to reengage in his or her current life; this includes re-establishing personal efficacy and secure social connections." (Turner, McFarlane and van der Kolk, 1996)

In a staged approach, the initial stage involves stabilization, helping a person develop his or her capacity to tolerate, manage and even reduce the intensity of emotions and emotional reactions, through various emotional regulation skills and practices. It also involves helping the person to create more stability in interpersonal relationships, partly through emotional regulation and partly through improved communication and problem-solving skills.

Trauma disrupts people's sense of safety, security, stability and coherence in their lives and in themselves. Security and stability are cultivated through emotional self-regulation, healthier interpersonal relationships, the ability to identify and communicate about emotions and states of mind, as well as enhancing the ability to engage in satisfying and rewarding activities – both work and pleasure. These all contribute to re-establishing a sense of normality, safety, security and stability.

This is crucial and valuable in and of itself as part of the recovery and healing process; it also makes it less threatening to engage in therapeutic work on traumatic experiences as there is then a sense of having increased one's capacity to cope, to deal with strong emotions, and therefore some degree of an experiential sense of having "gotten past it". Furthermore, the therapeutic work on the trauma itself is generally done through some form of exposure and/or desensitization work, which can trigger powerful traumatic feelings (i.e. posttraumatic reactions) and therefore it is essential that the person has developed their ability to tolerate and manage these feelings in order for the trauma treatment to be successful.

In her book Models of Trauma Treatment Priscilla Dass-Bailsford describes how this task of developing emotional self-regulation is highlighted in various approaches to the treatment of trauma. For example, in the chapter **A Stage Oriented Treatment Model** (Chu 1998):

> Behaviors that are self-destructive and high risk commonly occur among trauma survivors and increase their vulnerability to revictimization. A focus on self-care eradicates trauma survivors' feelings of unworthiness and instills a positive sense of identity. The control of traumatic symptoms, especially those that interfere with current functioning, reduces a client's sense of helplessness (Chu, 1998). Grounding and self soothing techniques such as deep breathing, squeezing the ball, or rubbing a stone can help clients overcome intrusive thoughts and reorient the moment.

In the same text, Dass-Bailsford states that a Cognitive Behavioral approach "primarily involves working with a client's cognitions to change emotions, thoughts, and behaviors." However, there is a similar focus on developing a client's ability to tolerate, manage and reduce emotional reactivity. CBT techniques used by trauma therapists focus on the following:

- learning skills for coping with anxiety (such as a breath retraining or biofeedback)

- using cognitive restructuring to change negative thoughts
- managing anger
- preparing for stress reactions
- handling future trauma symptoms
- addressing relapse prevention and other substance abuse issues
- communicating and relating effectively with people
- addressing thought distortions that usually follow exposure to trauma
- relaxation training and guided imagery

Marsha Linehan, the originator of Dialectical Behavior Therapy also emphasizes the need to help the client develop the ability to manage emotions. While DBT was designed for treating Borderline Personality Disorder there is a strong current of thought to the effect that BPD is in effect a form of interpersonal, developmental PTSD or, at minimum, a "by-product" of such trauma.):

> DBT assumes the problems of BPD individuals are twofold. First, they do not have many very important capabilities, including sufficient interpersonal skills, emotional and self regulation capacities (including the ability to self regulate biological systems) and the ability to tolerate distress. Second, personal and environmental factors block coping skills and interfere with self regulation abilities the individual does have, often reinforce maladaptive behavioral patterns, and punish improved adaptive behaviors.

So, as we see, over a wide range of well-established therapies for trauma - as well as in the above-cited expert opinion on the functions of trauma treatment – the importance for the client, and for the success of the therapeutic process, of focusing on learning and developing emotional regulation skills is primary. However, this task can be challenging for both the client and the therapist. Until people do learn to alter and regulate their patterns of reaction, they continue to get into and experience situations that trigger them; when situations trigger them, their reactions result in cascading effects that affect their ability to function, their relationships with others and their sense of self. This not only compounds and complicates their problems, but also magnifies their sense of hopelessness and of the futility of trying to change. This frequently interferes with and disrupts their confidence in therapy, and their adherence to therapy.

Within the framework of current thinking on “best practices,” then, it stands to reason that the most efficient and effective methods of emotional regulation and symptom reduction will result in the *most adherence to treatment* by the client, and the *most successful outcomes* of the treatment process. The more quickly and easily a client is able to learn and utilize the technique, and the more effective that technique is in actually reducing the intensity of

negative emotions, the more confidence the client will have in the therapist, the therapeutic process, and the potential of a successful outcome. Furthermore, the more the client is able to utilize such technique to better manage emotional reactions, the more quickly s/he will be able to create stability in his or her life, and to reduce the cycle of experiences described above.

Now, before I proceed any further I must make a note regarding "trauma therapy." Trauma therapy has many components and dimensions, and involves much more than the resolution of symptoms, even beyond what is noted in the quote on Page 1. For example, the therapeutic relationship can be a critical factor in the outcome of an individual's therapy. Sometimes people need to talk, to feel heard and understood more than anything else; sometimes they need to be educated about their condition. I do not propose – or believe – that any one technique or approach is sufficient or comprehensive enough for proper treatment of the traumatized *person.* I also agree with Besel van der Kolk when he says that "there is no such thing as a therapy of choice for trauma." (Keynote speech, 2011 ACEP conference.) The best therapies to use are determined by multiple factors including the therapist, the therapist's training and comfort, the client, etc. This is in part why I propose that it may be better to focus on integrating Energy Psychology into current "best practices" – i.e. into the existing body of practices of what works.

At the same time, we have established how critical symptom resolution *is* to successful trauma treatment. The resolution of symptoms, the reduction of the intensity of feeling reactions, is one of the demonstrated strengths of EP techniques; however, as we will see below, their benefits and utility in the therapeutic process go far beyond that.

Energy Psychology

According to Feinstein *"Energy Psychology may be described as a form of 'acupressure assisted exposure therapy'"* (Feinstein, 2010) and certainly, the term was coined in the context of techniques that utilize the stimulation of "acupoints", specifically TFT and its derivatives such as EFT. The definition of EP that I will use here is a broader one: *Energy Psychology techniques and approaches work on psychological issues and problems using methods and systems that explicitly involve the mind/body energetic system, including meridians, chakras and the bio field as well as other conceptualizations.*

Based on the research, on my own training, my own clinical experience and that of many other practitioners with whom I have discussed this directly, or whose written accounts I have read, I would propose that when we use EP techniques we work simultaneously on symptoms, on conditioned responses, on the narratives that contain and sustain these symptoms and conditioned responses, and on cognitions around the whole experience. All the EP methods with which I am familiar involve accessing a somatosensory response while engaging in an

activity that on the one hand, holds part of the attention in the present moment and on the other hand, explicitly and intentionally engages the mind/body, and thus the specific issue, as an energetic system. The specific “activity” of the technique characteristically acts to calm the emotional/ symptomatic responses even as it elicits them. In some techniques, the energetic system is intentionally engaged through acupressure points, in other techniques through the chakras or the bio field. In Logosynthesis, which I use extensively, the energetic system is accessed through intentional statements retrieving or releasing energy that is "frozen" or held in the construct and maintenance of the issue or problem.

Therefore, in all these techniques there are elements of exposure and of symptom reduction, and as all these techniques are easy to learn and to use, they are also methods of emotional self-regulation. While using the EP techniques and engaging the narrative that has developed about the event practitioners consistently find that symptoms – somatosensory /emotional responses to “triggers" – are quickly and effectively changed, i.e. either reduced or resolved, both within the session and, often, permanently. With this obviously comes a relief from suffering for the client, as well as increased hope and confidence in the possibility of change and resolution of the problem and, therefore, increased hope in the therapeutic process.

Practitioners also widely report that as symptoms are alleviated and responses are shifted, cognitions change quite naturally and organically. People's perceptions of the traumatic event literally change. Often they begin remembering a broader scope of details and often they will refer to it as "a memory… It's in the past now." They will often report that the memory no longer activates the emotional responses and feelings of distress it previously did. This can sometimes happen within one, two or three sessions of treatment – although this depends on the complexity of the trauma. Cognitions about the event change, the narrative about the event changes, and as a result cognitions about the self in the present change. People begin to see themselves as someone who is more "normal" than they previously perceived themselves, which then makes the idea of "living a normal life" a more tangible and reachable goal.

As people's emotional response patterns and cognitions change for the better, patterns of interpersonal interaction change for the better, creating more stable and rewarding relationships, and facilitating engagement in normal and productive activities.

So we see that the three functions/stages of trauma therapy as described above are all addressed and satisfied in the use of these techniques. Even more specifically and explicitly, if we look at a summary description of the “A- list” trauma treatments cited by the ISTSS (adapted from http://www.apa.org/monitor/jan08/ptsd.aspx with my comments in italics), we can easily see how the efficacy of EP methods in reducing various types of symptoms and altering emotional responses, often resulting in a shift of thoughts and perspectives on the situation being addressed, fits seamlessly into the existing frameworks of trauma treatment:

- **Prolonged-exposure therapy** ... In this type of treatment, a therapist guides the client to recall traumatic memories in a controlled fashion so that clients eventually regain mastery of their thoughts and feelings around the incident... Done in a gradual, controlled and repeated manner, until the person can evaluate their circumstances realistically and understand they can safely return to the activities in their current lives that they had been avoiding.

  This equally describes the use of EP approaches, although clinical experience of these approaches tends to generally result in a much quicker process that is less distressing to the client.

- **Cognitive-processing therapy**, a form of cognitive behavioral therapy, or CBT... This treatment includes an exposure component but places greater emphasis on cognitive strategies to help people alter erroneous thinking that has emerged because of the event. Practitioners may work with clients on false beliefs that the world is no longer safe, for example, or that they are incompetent because they have "let" a terrible event happen to them.

  As described above, the use of EP techniques and approaches results in a "natural and organic" shift to more adaptive thoughts and beliefs, requiring much less time and effort than a cognitive approach.

- **Stress-inoculation training**, another form of CBT, where practitioners teach clients techniques to manage and reduce anxiety, such as breathing, muscle relaxation and positive self-talk.

  Again, as we have discussed, EP techniques are very useful in performing these very functions of reducing anxiety, inducing a more relaxed state, and engendering adaptive cognitions and a positive sense of self.

- **Other forms of cognitive therapy**, including cognitive restructuring and cognitive therapy.

  See note above.

- **Eye-movement desensitization and reprocessing**, or EMDR, where the therapist guides clients to make eye movements or follow hand taps, for instance, at the same time they are recounting traumatic events.

  Many EP practitioners think of EMDR as an EP technique, although EMDR as a field rejects this. EMDR seems to work in much the same way as EP techniques and displays similar benefits over more “conventional” approaches.

> **Medications**, specifically selective serotonin reuptake inhibitors. Two in particular-paroxetine (Paxil) and sertaline (Zoloft)-have been approved by the Food and Drug Administration for use in PTSD. Other medications may be useful in treating PTSD as well, particularly when the person has additional disorders such as depression, anxiety or psychosis, the guidelines note.
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> *There are a number of problems with the use of medications, but the pertinent point here is that EP techniques are often quite successful in facilitating symptom reduction without the use of medications.*

In closing, then, I would reiterate my opening point. As we strive to obtain acceptance of EP approaches in the "mainstream", for example for the treatment of trauma, it is unnecessary – and even counterproductive – to champion these as completely new approaches that are in opposition to the "old approaches." The selling points of EP – the ways in which is the most effective and efficient – correspond closely to the goals and functions of current "best practices". Best practices are defined in a broad way, to include what has been clinically shown to work, not just what research has definitively “proven”. I would propose that advancing or promoting EP on this basis of building on and improving what already exists (and what people are already comfortable with) is probably a more effective strategy than positioning it as "new and different".

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