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Using energy psychology

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To put the world in order, we must first put the nation in order; to put the nation in order, we must put the family in order; to put the family in order, we must cultivate our personal life; and to cultivate our personal life, we must first set our hearts right.
Confucius, 551-479 BC

This is an account of my exploration of some of the emerging schools of energy psychology and how they can be integrated into clinical practice in a CAMHS setting. In particular, it explores the potential of energy psychology for clearing historical trauma which is impacting negatively on current parent-child attachment patterns.

Contemporary accounts from neuroscience, (e.g. Gerhardt, 2004; Siegel 1999) have begun, once more, to refer to emotion as energy, connecting mind and body with other minds and bodies. 'Energy' is a concept once known in Western thinking as 'vital force' but, later, this became deeply unfashionable: a casualty of the shift to a mechanistic, Cartesian view of the universe. However, in other cultures it has held a more enduring place. Chinese medicine's system of acupuncture refers to chi; a similar concept in Hinduism is prana. This revival of interest in the energy concept in some scientific circles over the last twenty years, runs parallel to the new discoveries in quantum physics which have challenged the mechanistic paradigm. Oschman (2003), for example, summarises pioneering research in the field of cell biology which points to new methods of demonstrating the existence of electromagnetic energy fields around cells and body systems, such as the heart and the brain. In the emerging paradigm of an interconnected universe, described first by the mystics (Capra, 1975), the old body/mind split falls away and it is no longer possible to regard the body, mind and the emotions separately: all are interconnected.

The heart provides an interesting example of emotion as a bodily event. Once thought to be a simple pump, the new field of neurocardiology (Armour & Ardell, 2004) reveals the heart to be a highly complex, self-regulating, information processing centre with its own functional brain that communicates with the cranial brain via the nervous and hormonal system. We can find examples of this system interacting with the rest of the body on an emotional level. Anger causes increased sympathetic and reduced parasympathetic activity. Changes in emotions are accompanied by predictable changes in heart rate, blood pressure, respiration and digestion. Heart rate variability monitors (McCraty *et al.*, 1995) demonstrate how exquisitely sensitive the heart is to second-to-second changes in our emotional states. Focusing on love or gratitude produces a coherent pattern on the monitor, while anger produces a more irregular reading. Patterns of coherence, it is claimed, are beneficial to our physical health and well being. Oschman's (2003) research also provides support for the long held claims of body psychotherapists and neo-Reichians that trauma is stored in the body and can be unblocked by a corrective energy flow.

Energy psychology offers another way of working at the interface between mind, body, and emotion. Crucially, the claim is that traumatic information is *encoded* in the energy field which is the interface between these domains, and that interventions which focus on the energy system can effectively clear trauma symptoms.

The development of energy psychology

The recognition of the impact of trauma, led to a search for more effective ways of treating its distressing and disabling symptoms. Simply talking often seemed not to be helpful, especially given the risks of re-traumatising (van der Kolk, 2002). The move away from talking cures towards energy-based methods has produced a diversity of approaches. In the early 1990s, frustrated with the limited success of talking cures, Charles Figley invited therapists in the trauma field to submit their various treatment programmes for research into their effectiveness. Eye movement desensitisation reprocessing (EMDR) and 'thought field therapy' were found to be the most effective (Carbonell & Figley, 1995).

Drawing on the work of George Goodheart and John Diamond (e.g. Diamond, 1979; Goodheart, 1989), Roger Callaghan (2001) developed 'thought field therapy' (TFT), one of the first energy psychology methods. Diamond, a psychiatrist with an analytic background, was interested in the connection between the model of the meridian system and the emotions. Goodheart was an applied kinaesiologist, who developed muscle testing – a means of interrogating the body-mind system and used extensively in most energy psychology approaches. Like many innovations, TFT arose out of clinical failure. Roger Callaghan, a traditionally trained clinical psychologist had been struggling for eighteen months, using all the tools of his trade, to treat a woman client with a severe and disabling case of water phobia. In a moment of desperation (no doubt familiar to us all!) and prompted by her description of the anxiety she experienced in her stomach when focussing on the water phobia, he suggested that his client tap on a stomach meridian point just below the eye. To his astonishment – and hers – her anxiety instantly cleared. This success led to further studies of the relationship between, what Callaghan termed 'perturbations in the thought field', and the possibility of clearing such disturbances through stimulating the appropriate meridian points.

Gary Craig, a student of Callaghan, modified and simplified TFT, and called his method 'emotional freedom therapy' (EFT). This is a popular self-help method which can be learned very quickly. A free manual can be downloaded from his website (*www.emofree.com*). Various other schools of energy psychology have developed, each reflecting the particular theoretical orientation of its founder. For example, 'advanced integrative therapy' (AIT) – *www.seemorg.com* – is a highly sophisticated model developed by Asha Clinton, a Jungian psychotherapist. AIT integrates Jungian psychology, object relations, cognitive behavioural therapy, and transpersonal approaches.

Phil Mollon, a British analyst, psychotherapist and clinical psychologist, has studied all of the branches of energy psychology and developed his own integrative approach which he terms 'psychoanalytic energy psychotherapy' (PEP) – *www.philmollon.co.uk*. He has also written one of the most comprehensive books on the whole field, to date (Mollon, 2008). Tapas Fleming, an acupuncturist, has her own simple and very elegant approach, 'tapas acupressure technique' (TAT) (*www.tatlife.com*) which I have also found to be very helpful.

It is not possible to describe in detail each of the modalities to which I refer. Readers who wish to know more about the methods and the trainings available are referred to the websites listed above. A comprehensive summary of the current evidence base is available in Mollon (2008). He cites a range of evidence for efficacy and effectiveness, which includes randomised control trials, field studies of the treatment of post traumatic stress disorder (PTSD) in disaster areas, as well as thousands of individual case studies.

Integrating energy psychology into family therapy

As a humanist and integrative psychotherapist, working as a family therapist, I have become interested in exploring ways in which the release of individual traumas through these methods

can also bring about a healing shift in the relational system. What can we do when clients report – as they so oft en do – emotions such as rage and shame and hatred, which have become destructive to themselves, or to others close to them? A sympathetic exploration of the roots of the difficulties, a search for alternative perspectives can all be helpful. Empathic understanding can be healing in itself. It may not, however, be sufficient to bring about deep and lasting change in the intensity of powerfully distressing and even destructive emotions especially in short term work.

Having discovered how startlingly rapid and effective these techniques can be in individual work, I have begun to explore their potential when working with families. Although all the different modalities may appear simple, there is an art to their delivery. In working with families the challenge is to determine where, when and with whom to intervene. I have begun to set my therapeutic antennae to seek the traumas in the narratives. I find it helpful to use the very broad definition of trauma put forward by Shapiro (2001) who refers to 'big T' and 'litt le t' traumas. Asha Clinton's (AIT) definition is also valuable in its precision.

Everything that impinges in a hurtful way on a person to the point that it triggers difficult emotions, physical pain, negative beliefs, spiritual and /or dissociation, IS trauma – and can be treated as such (Clinton 2006, p. 99).

In my history-taking I pay particular attention to 'bad memories'. Influenced by AIT, I seek to identify the traumas of the past which are reflected in the relational problem in the present. There is of course nothing new in this clinical approach. What is new is the possibility of using energy psychology methods to rapidly clear the traumas, which are now interfering in the present, to facilitate a different trauma free pattern of relating.

The following case examples illustrate how these methods can be integrated into clinical practice.

Taking the heat out of an enflamed mother/son relationship with AIT

Aaron, a 15-year-old white-British boy, was referred because of a marked deterioration in his behaviour, both at school, and in his relationship with Emma, his lone parent mother. He had become very defiant of authority, had got into 'bad company' and his grades had dropped dramatically. Initial assessment had revealed that he had been previously a strongly parentified boy, supporting his mother through several major crises and a period of depression. His younger sibling had a diagnosis of autistic spectrum disorders (ASD) and attention deficit hyperactivity disorder (ADHD).

I observed how intensely reactive Emma had become towards Aaron who, in turn, had become increasingly defiant and oppositional. His transition into older adolescence had become a war zone. In a session with both of them present, Emma angrily declared that Aaron "treated her like crap" and she wasn't putting up with it any more. I observed how emotionally charged her words were, and asked who else had treated her in this way. She cited all her major attachment figures from childhood and throughout her adult life. Emma agreed to see me on her own and to work on her intense feelings of rage, frustration, and bitterness which she recognised were flooding her relationship with her son.

AIT involves identifying the energy centre in the body where intense and troubling feelings are held: in this case her solar plexus. I asked Emma to place one hand on her solar plexus while repeating the treatment phrase "all the people who treated me like crap and I didn't deserve it", and guided her to use her other hand to briefly hold each of the energy centres of the body. The energy centres correspond to the chakra system – another map of the energy field, originating in ancient India. Strange as it may sound, my experience is

that people are willing to do this if they are well-engaged and if the method is presented with confidence. I find it helpful to quote one young adolescent's comment "It's weird, but it works!"

Part of the protocol of AIT is to obtain a subjective unit of distress (SUD), a simple 1-10 rating scale of the level of disturbance of the traumatic memory as it is experienced in the present. After two rounds of AIT as described above, much to her surprise, Emma reported a rating drop from nine to three. At this stage I checked to see if there was some resistance to clearing all her intense feelings. Consciously she was aware of, and able to articulate, a resistance to letting go of her remaining anger – "If I stop being angry *they* will be let off the hook" – I then worked on the resistance using a different energy technique, af er which her SUD reduce to zero. Emma commented, with some surprise, on how calm and peaceful she felt. I saw her the following week and she reported that the number of confrontations had dropped dramatically. When Aaron tried to escalate the conflict, she was able to remain calm. To my surprise, she also reported a change in her relationships with colleagues. She found herself more able to deal with conflict, rather than avoiding it. Several conventional sessions of family therapy followed. This change was maintained over several months and Aaron is currently doing well. Emma continued to feel much calmer generally and, at follow-up was appreciative of how free she still felt of the anger and bitterness which she had carried for so long.

Clearing emotional blocks in a mother/daughter relationship

Amy, a twelve-year-old white British girl, was referred because of longstanding concerns about aggressive outbursts at home and a history of bedwetting. At the first meeting, Caroline, her mother, revealed that she had always had a difficulty in relating to her daughter, experiencing acute bodily discomfort when Amy tried to come close. Caroline said there was a history of difficult mother/daughter relationships in her family, and she wanted to be able to change this. She experienced no such intolerance of closeness in relation to her older son to whom she seemed securely attached. An exploration of Caroline's early history led to the hypothesis that the somatised anxiety and hostility, which was evoked by Amy's comfort seeking behaviour, had its roots in her early experience of Caroline's mother's rejection of Caroline's comfort-seeking as a child. At this stage I introduced the suggestion that we try some energy psychology methods to see if these would help. Focussing on the "washing machine feeling" in her stomach with TAT brought her considerable relief in the session. A week later she reported that she had been very tearful for the rest of the day (she rarely cried) but was able to tolerate this and even welcomed it as an emotional release. The longstanding tension with her daughter was hugely diminished and she became able to enjoy a new and relaxed intimacy with Amy.

In a later session, during a half-term, Caroline came in a very agitated state: there had been an angry scene at home that day involving both the children. It emerged that she dreaded half-terms and, in particular, could not bear it when the children squabbled. She either lost her temper or tearfully withdrew, and made frequent phone calls to her husband to report on the children's 'bad' behaviour. Following the AIT method of seeking the originating trauma underlying the present difficulty, I learned that her parents used to have many arguments which she experienced as very frightening. As a child, Caroline found them unbearable and tried to block them out by covering her head with a pillow. We then worked on this originating trauma and the linking cognition – "Because I used to hide to protect myself from my parents' frightening fights I feel scared and withdraw when my children squabble". Afterwards, Caroline reported feeling very calm, and confirmed, when we next met, that her children's squabbling no

longer re-stimulated her early distress. She was able to tolerate, without collapse, an angry scene with Amy who was then able to tell her about some bullying at school, which her mother was then able to help her with. A follow-up session three months later indicated that Caroline's relationship with Amy continued to be warm and playful. I asked Caroline what had been helpful: "It was when you took a way that washing machine feeling', she reported, 'and the talking."

Conclusion

Looking back, I have experienced different phases in exploring these methods. Having embarked on the journey with some scepticism, I quickly moved into a phase of great enthusiasm and was tempted to try these new methods on everything. Most recently I have come to appreciate the limitations of the more technique based approaches such as TFT. Sometimes well-engaged clients, who seemed to have experienced real relief from these methods, have told me that they would prefer just to talk. This seems to happen particularly with adolescents who have not received much empathic understanding from carers. There may also be some resistance to the technique aspect of the treatment approaches, a problem which also arises with EMDR. Th is reservation does not apply to the more sophisticated models such as AIT and PEP which recognise the importance of the reparative relationship as well as the value of trauma removal. A rich repertoire of therapeutic knowledge and skills is as important as ever. And, when introducing new and undoubtedly strange approaches to our clients, a close attention to any potential difficulties in the alliance is crucial.

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