REVIEW ARTICLE

Energy Psychology in Rehabilitation: Origins, Clinical Applications, and Theory

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Abstract

Three forces have dominated psychology and psychological treatment at different times since the early 1900s. The first force was Freudian psychoanalysis and its offshoots that focus on unconscious psychodynamics and developmental fixations, with principal therapeutic techniques including free association, dream analysis, interpretation, and abreaction. Second came behaviorism, spearheaded by Pavlov, Watson, and Skinner, which emphasized environmental stimuli and conditioning—its techniques including respondent and operant conditioning, exposure, desensitization, schedules of reinforcement, modeling, and more. The third force involved humanistic and transpersonal approaches that attend to values and choice, including client-centered therapy, gestalt therapy, phenomenology, and cognitive therapy, some of the principal leaders being Rogers, Maslow, Perls, Rollo May, Binswanger, and Ellis. Recently the new paradigm of *energy psychology* has emerged, which may be considered psychology's *fourth force*. The earliest pioneers included Goodheart, Diamond, and Callahan. This theoretical and practice approach offers the field some unique findings, as it views psychological problems as body–mind interactions and bioenergy fields, providing treatments that directly and efficiently address these substrates. Some of energy psychology's techniques include stimulating acupoints and chakras, specific body postures, affirmations, imagery, manual muscle testing, and an emphasis on intention. This review covers energy psychology's historical development and experimental evidence base. Case illustrations and treatment protocols are discussed for the treatment of psychological trauma and physical pain, two of the most important and ubiquitous aspects common to rehabilitation conditions. Additionally, the research on energy psychology is highlighted, and the distinction between global treatments and causal energy diagnostic-treatment approaches to treatment is addressed.

Keywords: acupuncture, research, quantum mechanics, Thought Field Therapy (TFT), Advanced Energy Psychology (AEP), rehabilitation, pain.

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Bioenergy Fields

Approximately 7,000 years ago in India it was believed that the human body has an energy system extending beyond its physical boundaries—namely, auras or biofields and chakras, which are vortices extending out from or into the material body at key locations. A visual representation of biofields showed up in portraits of saintly people with halos around their heads or entire bodies. Perhaps the artists simply painted the halos to suggest holiness, or possibly they were psychically attuned to actually see the biofields.

Initial scientific investigations in this area were made by Harold Saxon Burr (1976), who employed electronic devices to investigate Life fields or L-fields that were demonstrated to surround humans, animals, trees, and inanimate objects. Valerie V. Hunt (1989) also used electronic equipment to study various biofield manifestations that occur during healing. While biofields may be seen as epiphenomena, they may possibly precede and be more fundamental than the physical body. That is, biofields may be similar to blueprints or

molds, which similarity accounts for the bodily form. This position is partly suggested by the fact that approximately every 4 years our bodies shed every atom and molecule and yet maintain their essential physical structure.

Acupuncture Meridians

About 4,500 to 5,000 years ago, some people in China came to believe that there exist pathways of energy within the physical body, referred to as meridians. The Chinese designated 12 primary meridians involving organ systems, two collector meridians or vessels, and eight extraordinary vessels. Each is a distinct pathway, along which exist tiny portals where electrical resistance is lower than it is in the surrounding skin. The meridians and vessels were described in the *NeiJing* or *The Yellow Emperor's Classic of Internal Medicine*. This 24-volume work details two ways of working with the meridians: needles and moxa (an herb that is caused to smolder at the location of acupoints). The basic notion is that *chi* energy flows through the meridians and vessels and that they can develop imbalances that result in illness.

We can only guess about how the Chinese posited energy meridians and vessels. To the best of our knowledge, they did not have sophisticated electronic equipment in those days. One possibility is that the pathways were mapped as a result of soldiers being injured in battle. For example, given an injury at a location related to a specific meridian, a soldier's chronic physical malady might clear up or improve. Another theory is that tailors accidentally stuck their patrons with needles and came to speculate that being stuck at those locations accounted for the resolution of a physical malady. Still another hypothesis is that the discoverers of meridians possessed extrasensory perceptual abilities that made it possible for them to actually see the energy pathways.

The goal of meridian therapies is to reinstate balance and health by addressing key acupoints along disrupted meridians. It should be noted that each meridian has a tonification point, which is used to stimulate the meridian; a sedation point, which is used to sedate the meridian; a source point, which is used to activate the whole of the meridian; and a number of additional types of acupoints. While the meridians are integrally interconnected, indicating that there is only one continuous meridian or meridian system, there nonetheless appears to be some specificity of meridians and acupoints. While meridian–emotional connections are included in the historic five elements theory, more recently Diamond (1985) has observed via manual muscle testing that the lung meridian is associated with humility versus intolerance, the gall bladder meridian with love versus rage, and the spleen meridian with confidence versus anxiety about the future. For instance, research on specific acupoints have shown that the sixth acupoint on the pericardium meridian (PC-6), which is located two in. (inches) above the transverse wrist crease at the middle of the palm side of the forearm, is effective in treating motion sickness, morning sickness, and nausea (McMillan, 1998).

In the early 1970s, Robert O. Becker and colleagues (Becker, 1990; Becker & Selden 1985) researched electrical skin resistance related to acupoints. He found that many of the acupoints along the pericardium meridian and large intestine meridian lines on the forearms of his subjects evidenced lower electrical resistance compared with the surrounding skin. Additionally, researchers in France (de Vernejoul, Albarede, & Darras, 1985) have provided some radiological evidence for the existence of meridians.

The Physics of Energy

In 1905 Albert Einstein published four original articles that have transformed our perception of reality. His article on the photoelectric effect, which won him the Nobel Prize, introduced the quantum of light. He also wrote about Brownian motion, helping to establish the reality of atoms. And then there were the paradigm-shaking special and general theories of relativity. In these articles he established that while the speed of light is a constant, there are no absolute reference frames or absolute velocities—that the position of the observer determines what can be observed. He also concluded that matter and energy are interconvertible aspects of the same basic reality. Fundamentally, everything in the known universe is reducible to energy organized into fields. While subatomic phenomena, such as electrons and photons, can manifest as particles or waves, physicists researching atoms with particle accelerators or "atom smashers" have been unable to discern the most essential particle, again pointing to energy and fields as fundamental to the structure of material reality.

Quantum mechanics is an attempt to explain energy and the mysteriousness of our universe. For example, it has been discovered that energy rather than being a continuous phenomenon, exists discontinuously or in packets referred to as quanta. Additionally, quantum physicists have had to contend with other odd findings about reality, especially the phenomena of *complementarity*, *uncertainty*, *nonlocality*, and *information fields*.

Complementarity is illustrated by the fact that an electron paradoxically will reveal itself as either a particle or a wave, depending upon the experiment conducted to observe it. Electrons and other subatomic elements appear to be simultaneously particles and waves.

Uncertainty is evidenced by the fact that if we know the location of a subatomic "particle," then we can only make probability statements about its speed. Conversely, if we know the speed of a subatomic "particle," we can only make probability statements about its location.

Nonlocality is shown in that there appears to be a holographic interconnection throughout the universe that transcends time, space, and velocity. A number of physics experiments have demonstrated that the communication exchange between "intimately" related photons occurs astronomically faster than light speed, although speed really has nothing to do with it (Aspect & Grangier, 1986; Clauser, Horne, & Shimony, 1978; Tittel, Brendel, Zbinden, & Gisin, 1998). The interconnection is practically instantaneous.

Another interesting finding, explicit in the work of Davies (1999) and Prigogine (1996), is that systems become information rich as they are forced farther from equilibrium or symmetry. Conversely, symmetrical systems are information poor.Information appears to be a function of structure and shape, and similar to atoms and molecules, it appears that information is fundamentally a manifestation of energy and fields.

The phenomena of nonlocality, complementarity, uncertainty, and information fields reveal that the universe does not conform to our logic and that perhaps it is saturated with consciousness and choice.Complementarity alone brings to mind the humorous The *Far Side* cartoon in which cows behave as cows in the field only when humans drive by and otherwise engage in human-like conversation when humans are no longer in sight. Cow 1 does not equal Cow 2. Only, instead of cows, we are observing or not observing the behavior of electrons and other subatomic "particles."We might have to ask Newton what those particles are up to when we are not observing them.

Applied Kinesiology

In 1964, George A. Goodheart Jr., a chiropractor from Detroit, Michigan, began to carve out the field of applied kinesiology (AK). He utilized manual muscle testing from physical therapy (Kendell & Kendell, 1949) to assess the integrity of various systems throughout the body, not merely the physiological status of the isolated muscle. The commonsense assumption here is that the body is an integrated whole and that interconnection exists among the various systems, which are fundamentally useful but artificial distinctions. If a muscle tests *on* or "strong," obviously this has different implications than if it tests *off* or "weak." In addition to discovering that weakness in a muscle can be caused by hypertonicity in an opposing muscle, he also found that the hypertonic or hypotonic muscle can be relaxed or strengthened by addressing neurolymphatic reflexes, neurovascular reflexes, cranial faults, exogenous substances, and the acupuncture meridian system, respectively (Goodheart, 1987; Walther, 1988).

Not surprisingly, Goodheart also found that emotions could be causal in the development, exacerbation, and sustaining of a physical problem. He discovered that he could employ specific neurovascular reflexes, located at the frontal eminence on the forehead, to treat emotional factors. This is referred to as the emotional stress release (ESR) procedure. If there is an emotional component to a condition, testing an associated indicator muscle while challenging the emotional neurovasculars (a procedure called *therapy localization*) will result in a change in the indicator muscle response. Thereupon either the patient or therapist can hold the ESR points for a period of time to treat the emotional component. In this case, it may be helpful, but is not essential, that the patient think about the emotional issue while the ESR procedure is being employed. Thus, this procedure also appears to be effective with patients who do not have conscious access to the emotional issue.

In a psychotherapeutic context, ESR can be used to reduce stress associated with issues in the patient's life, without having to localize the problem, and perform manual muscle testing. The pa-

tient simply attunes or thinks about the issue (e.g., traumatic memory, phobia, feelings of depression) and lightly holds the emotional neurovasculars with his or her fingertips while monitoring decrease in emotional distress. While ESR will usually result in a significant temporary decrease in the level of emotional distress associated with the issue, frequently it results in ongoing emotional relief. I have found that it is often useful and effective to combine ESR with relevant affirmations. For example, while using ESR to treat anger, the patient may find it beneficial to affirm concomitantly "I release myself of this anger" or "There is forgiveness in my heart."

Life Energy Analysis

In the 1970s, John Diamond, a psychiatrist involved in preventative medicine, studied AK and integrated these findings with psychoanalytic understandings, utilizing the acupuncture meridian system to diagnose and treat psychological problems (Diamond, 1978, 1985). In recent history, this was the beginning of meridian-based therapy. Diamond's method, referred to as behavioral kinesiology (BK) to distinguish it from AK, involves assessing the integrity of the patient's acupuncture meridian system and drawing conclusions about prominent emotional issues involved in the individual's functioning. He employs a wide array of techniques and modalities to treat emotional factors, including the thymus thump, positive affirmations, music, sounds, gestures, postural adjustments, nutritional supplements, flower essences, and more. He also introduced the concept of "reversal of the body morality," which represents a significant block to treatment effectiveness. In this regard, the "reversed" person is responding as though what is unhealthy is healthy. Diamond has explored various ways of correcting for this problem, including providing nutritional supplements, altering negative life decisions, and resolving relevant negative feelings in relationship to one's mother.

Thought Field Therapy

In 1979, Roger A. Callahan began to elaborate on certain aspects of Goodheart's and Diamond's work. He studied AK and utilized Diamond's straight arm technique for manual muscle testing (Callahan, 1985, 2001). His approach was initially referred to as the Callahan techniques and later as thought field therapy (TFT). Double-negative testing (Diamond, 1985) is used to therapy localize meridian alarm points while the patient attunes the thought field associated with a phobia, trauma, and the like. In Callahan's view, this procedure makes it possible to define the energetic elements or sequences of meridian points involved in a psychological problem. He found that physically tapping on beginning and ending points of meridians reinstated harmony in the meridian by neutralizing the negative emotions associated with the psychological problem. He also developed diagnostic and treatment procedures to correct psychological reversal, which blocks treatment effectiveness. Additionally, Callahan developed a *Voice Technology* for diagnosing and treating clients over the telephone. TFT and energy therapy in general have gone in a myriad of directions, with various clinicians offering their refinements and advancements (Durlacher, 1994; Furman & Gallo, 2000; Gallo, 2000, 2002, 2005; Gallo & Vincenzi, 2008). Many of these approaches have roots in TFT, BK, and AK, combined with other methods.

Advanced Energy Psychology

Influenced by the work of Goodheart (1987), Diamond (1979), Callahan (1985), Pransky (1992), Mills (1995), and others, Gallo (2000) developed energy diagnostic and treatment methods (EDxTM) in the early 1990s and later referred to as Advanced Energy Psychology (AEP; Gallo 2000). Comparable to BK and TFT, AEP uses muscle testing, therapy localization, and alarm points to diagnose and treat meridian disruptions associated with psychological problems; however, AEP also identifies a variety of psychological reversals, a wider range of acupoints, and does not assume that a sequence of meridian points is needed to correct a problem. Also, similar to acupuncture, a single acupoint or cluster of acupoints is often employed.

While AEP is a meridian-based therapy, it also addresses other aspects of the energy system and incorporates a wide variety of cognitive and energetic-based procedures. Other modalities include imagery, affirmations, redecision, identification and alteration of core beliefs, music and poetry, and elevation of clients' consciousness of the effects of thought (Gallo, 2000, 2002, 2005).

Research

A body of empirical research on energy psychology has emerged in the past decade, much of it published in peer-reviewed medical and psychology journals. It includes several randomized controlled trials (RCTs), the "gold standard" of evidence-based medicine. It also includes several important uncontrolled trials, in which subjects served as their own controls, with measurements taken over time to assess client progress, as well as some small pilot studies and collections of case histories that are suggestive of future research directions.

These studies support the effectiveness of energy psychology in the treatment of fibromyalgia (Brattberg, 2008), PTSD (Carbonell & Figley, 1996, 1999; Church, 2009b; Church, Geronilla, & Dinter, 2009; Church, Hawk, et al., 2009; Church, Piña, Reategui, & Brooks, 2009; Diepold & Goldstein, 2008; Figley, Carbonell, Boscarino, & Chang, 1999; Green, 2002; Johnson, Shala, Sejdijaj, Odell, & Dabishevci, 2001; Sakai 2007), phobias and anxiety (Callahan, 1987; Leonoff, 1995; Wells, Polglase, Andrews,Carrington, & Baker, 2003), phobias and self-concept (Wade, 1990), acrophobia (Carbonell, 1997), blood-injection-injury phobia (Darby, 2001), public speaking anxiety (Schoninger, 2001), various specific phobias (Salas, Brooks, & Rowe, 2009), and physical pain and other clinical problems (Church & Brooks, in press; Pignotti & Steinberg, 2001; Sakai et al., 2001).

Callahan's (1987) and Leonoff's (1995) studies showed significant decreases in subjective units of distress (SUD) ratings. They had many methodological shortcomings, given the nature of the methodologies, which involved treating call-in subjects on radio talk shows. They could not include control groups, placebo treatments, follow-up evaluations, or other evaluative measures. Although the most demanding researcher would dismiss these studies, as they merely demonstrate that the procedure was able to decrease the subjects' discomfort at the time, it is interesting that the same level of criticism is not invariably raised when a psychopharmacological study demonstrates that a benzodiazepine or a beta blocker is able to relieve anxiety or deter a phobic response. Follow-up studies would seldom support the effectiveness of the psychotropic in relieving the phobia or anxiety disorder over time, after the agent has been discontinued. Nonetheless, the ability of a treatment to afford even temporary relief is considered acceptable by the medical community and the general public.

Callahan's (1987) and Leonoff's (1995) studies entailed the same number of subjects, 68, with various phobic and other anxiety complaints. All told, 132 of the 136 subjects were successfully treated with TFT. This translated into a 97% success rate, which is really unheard of in the field of psychotherapy. What is perhaps even more significant in some respects is the fact that the total treatment times were exceptionally low, which is also uncommon in the field. Callahan's average treatment time was 4.34 min and Leonoff's was 6.04 min. Within those time frames, the mean decrease in the SUD was 6.25 for Callahan's subjects and 6.61 for Leonoff's. Across both studies, an overall mean decrease in the SUD was 6.43. Table 1 shows a summary of those statistics.

Carbonell and Figley's (1996, 1999) studies were undertaken at Florida State University and took the form of a systematic clinical demonstration project. They evaluated the effectiveness of TFT and a number of other approaches, including visual/kinesthetic dissociation, EMDR (EMDR), and traumatic incident reduction in the treatment of PTSD symptoms. These studies were sophisticated and detailed in evaluative measures and also included follow-along and follow-up assessments. Follow-up evaluations within the 4- to 6-month range revealed that all of the approaches yielded sustained reduction in SUD, although minimal rebound in SUD

Table 1. Telephone Therapy of Phobias and Anxiety on Call-in Radio Programs

Variable	Callahan (1985)	Leonoff (1995)
Programs, *n*	23	36
Subjects treated, *n*	68	68
Effectively treated, *n*	66	66
Success rate, %	97	97
Mean pre-SUD	8.35 (1–10 scale)	8.19 (0–-10 scale)
Mean post-SUD	2.10	1.58
Mean SUD decrease	6.25	6.61
Mean treatment time	4.34 min	6.04 min

Note. SUD = subjective units of distress.

was evident in many cases. Although follow-up evaluation time frames and the number of subjects varied considerably across treatment conditions, the researchers' introduction of confounding variables, respective mean group treatment times, and post-treatment follow-up SUD ratings provided preliminary data on the effects of the treatments. The results are summarized in Table 2.

Wade's (1990) and Carbonell's (1997) studies included control groups, randomization, paper-and-pencil measures, and SUD ratings. Carbonell's study also included double-blind procedures, placebo controls, and behavioral measures.

Wade's (1990) study was a doctoral dissertation. It included 28 experimental subjects and 25 controls. Two self-concept questionnaires were employed in the study, the Tennessee Self-Concept Scale and the Self-Concept Evaluation of Location Form. Approximately 1 month after these instruments were administered, the experimental subjects were treated in a group with the following TFT treatment points drawn from traditional Chinese acupuncture charts: Stomach-1 (*ue* or under the eye), Spleen-21 (*ua* or under the arm), Bladder-2 (*eb* or beginning of the eyebrow), and treatment for psychological reversal, which includes Small Intestine-3 in conjunction with the associated affirmation. Sixteen of the subjects evidenced a drop in SUD ratings of 4 or more points, while only four of the no treatment controls showed a decrease in the SUD of 2 or more points. Two months after treatment and 3 months after the original questionnaires were administered, the questionnaires were repeated. Analysis of variance revealed modest but significant improvements in three of the scales: the Self-Acceptance subscale of the Tennessee Self-Concept Scale and the Self-Esteem and Self-Incongruency subscales of the Self-Concept Evaluation of Location Form. Results support the effectiveness of a TFT phobia treatment and the hypothesis that the treatment can affect one's self-concept.

Table 2. Florida State University Active Ingredients Project Data

Method	Subjects	Time (min)	Pre-SUD	Post-SUD
V/KD	8	113	4.75	3.25
EMDR	6	172	5.00	2.00
TIR	2	254	6.50	3.40
TFT	12	63	6.30	3.00

Note. SUD = subjective units of distress; V/KD = visual/kinesthetic dissociation; EMDR = eye movement desensitization and reprocessing; TIR = traumatic incident reduction; TFT = thought field therapy.

Carbonell's (1997) study investigated the effectiveness of TFT in the treatment of acrophobia, or fear of height. The 49 subjects of the study were college students, initially screened from a total subject pool of 156 students with the Acrophobia Questionnaire (Baker, Cohen, & Saunders, 1973). All subjects completed a behavioral measure that involved approaching and possibly climbing a 4-foot ladder. A 4-foot path leading to the ladder was also calibrated in 1-foot segments. As the subject approached and climbed the ladder, SUD ratings using a 0–10 scale were taken at each floor segment and rung. Subjects were permitted to discontinue the task at any time. After these preliminary measures were obtained, the subject met with another experimenter in a separate room, and SUD ratings were obtained while the subject thought about an anxiety-provoking situation related to height. Subjects were then randomly assigned to one of two groups: TFT phobia treatment or placebo "treatment." While all of the subjects did the psychological reversal treatment at the onset, for the tapping sequence, the placebo group tapped on body parts not employed in TFT. After these procedures were conducted, SUD measures were obtained again. If the subject did not obtain a rating of 0, the respective procedure (experimental or placebo control) was administered once again. Posttesting was invariably conducted after the second administration of the procedure. Afterward, the subject returned to the initial experimenter, who was blind to the treatment received by the subject, for posttesting. Posttesting was the same as pretesting, which involved in vivo assessment of SUD ratings as the subject approached and possibly climbed the ladder. Prior to data analysis, comparison of the groups on pretreatment measures revealed that the groups were essentially equivalent.

"Although both groups got somewhat better there was a statistically significant difference between those subjects who had received real TFT and those who received placebo, with the TFT subjects showing significantly more improvement. There was a significant difference when all the SUD scores were averaged for each subject and the difference was more pronounced when examining the SUD scores of the subjects while climbing the ladder" (Carbonell, 1997, p. 1).

Darby (2001) reported in his doctoral dissertation that involved the utilization of TFT in the treatment of 20 patients with blood-injection-injury phobia. Measures included SUD and a fear inventory. Treatment time was limited to 1 hr with the diagnostic approach to TFT. Although the study contains many methodological flaws (i.e., the experimenter collected the data and administered the treatments), 1-month follow-up measures yielded statistically significant treatment effects.

Diepold and Goldstein (2008) conducted a case study of TFT with evaluation by quantitative electroencephalogram. Statistically abnormal brain-wave patterns were recorded when the patient thought about a trauma compared with thinking about a neutral (baseline) event. Reassessment of the brain-wave patterns associated with the traumatic memory immediately after TFT diagnosis and treatment revealed no statistical abnormalities. An 18-month follow-up indicated that the patient continued to be free of emotional upset regarding the treated trauma. This case study supports the hypothesis that negative emotion has a measurable effect and also objectively identifies an immediate and lasting neuroenergetic change in the direction of normalcy and health after TFT.

Johnson et al. (2001) reported on uncontrolled treatment of trauma victims in Kosovo with TFT during five separate 2-week trips in the year 2000. Treatments were given to 105 Albanian patients with 249 separate violent traumatic incidents. The traumas included rape, torture, and witnessing the massacre of loved ones. Total relief of the traumas was reported by 103 of the patients and for 247 of the 249 separate traumas treated. Follow-up data averaging 5 months revealed no relapses. While this data is based on uncontrolled treatments, the absence of relapse ought to pique researchers' attention, as a 98% spontaneous remission from posttraumatic stress is unlikely.

Sakai et al. (2001) reported on an uncontrolled study of 1,594 applications of TFT in the treatment of 714 patients with a variety of clinical problems, including anxiety, adjustment disorder with anxiety and depression, anxiety due to medical condition, anger, acute stress, bereavement, chronic pain, cravings, panic, PTSD, and trichotillomania. Paired *t* tests of pre- and posttreatment-SUD were statistically significant at the .01 level in 31 categories.

Pignotti and Steinberg (2001) reported on 39 uncontrolled cases that were treated for a variety of clinical problems with TFT, observing that in most cases improvement in SUD coincided with improvement in heart rate variability (HRV), which tends to be stable and place bofree. The authors suggested that HRV can be employed to objectively evaluate the effectiveness of psychotherapy treatment.

Several other energy psychology approaches have been subjected to experimental tests. Efficacy in reducing or eliminating symptoms of PTSD, such as anxiety, depression, and phobias, has been demonstrated in several studies of emotional freedom techniques (EFT)—a method that involves tapping on several of the acupoints used in TFT (Church & Brooks, in press; Rowe, 2005; Wells et al., 2003). Rowe (2005) gathered data on the depth and breadth of psychological symptoms, as well as specific conditions such as anxiety and depression, before and after a weekend EFT workshop conducted by EFT founder Gary Craig. He measured the symptoms of 104 subjects a month before the workshop, immediately before the workshop, immediately afterward, and at two follow-up points. The first two data points were unchanged, indicating that symptoms were not spontaneously improving due to the passage of time. Symptoms dropped significantly after the workshop, with most of the benefits maintained at the two follow-up points. Church and Brooks (in press) used similar psychological assessments, although the intervention was only 2 hr of self-applied EFT during the course of a series of five 1-day workshops taught to 216 healthcare professionals, such as nurses, doctors, chiropractors, psychotherapists, and alternative medicine practitioners. They found similar effects, though the intervention was very brief. A follow-up showed that the results held over time.

This study also extended Rowe (2005) in that it was the first to analyze whether those who continued practicing EFT afterward improved more than those who did not. It found a statistically significant correlation between frequency of EFT use after the workshop and symptom reduction. It also found no significant difference between the one workshop taught by EFT's founder, Gary Craig, and the four taught by Church, indicating that the beneficial effects of EFT are not due solely to unique abilities of the method's founder.

It also examined participant SUD scores for pain and cravings before and after 20-min segments of the workshops that addressed those particular issues. Physical pain decreased by 68% after EFT,

$p < .001$). Cravings for substances such as drugs, tobacco, chocolate, and alcohol fell by 83% ($p < .001$). When findings such as this are compared with pharmaceutical treatments for pain and cravings, it is apparent that a nondrug, side-effect-free, self-administered, and brief intervention such as EFT has a role to play in primary healthcare. Church and Brooks (in press) also examined the SUD scores of participants recalling a vividly traumatic childhood memory. After applying EFT for about 20 min, the authors found that scores of emotional distress relating to that memory dropped by 83% ($p < .001$).

Replication of Rowe's study of weekend EFT workshops offered by a variety of practitioners has been undertaken by Brooks and Church and has found similar effects (personal communication, November 20, 2009). However, Brooks and Church extended Rowe's findings by also measuring pain, cravings, and emotional triggers, and they found results similar to those reported in their earlier study of healthcare workers (Church & Brooks, in press).

A clinical trial compared EFT with diaphragmatic breathing for the treatment of specific phobias of small animals (Wells et al., 2003). Subjects were randomly assigned and treated individually for 30 min with meridian tapping ($n = 18$) or diaphragmatic breathing ($n = 17$). Statistical analyses revealed that both treatments produced significant improvements in phobic reactions, although tapping on meridian points produced significantly greater improvement behaviorally and on three self-report measures. The greater improvement for the energy technique was maintained at 6 to 9 months follow-up on the behavioral measure (i.e., avoidance behavior). These results were achieved in a single 30-min treatment without inducing the anxiety typical of traditional exposure therapies and without in vivo exposure to the animals during the treatment phases. These results were replicated in similar EFT studies by Baker and Siegel (2005) and Salas et al. (2009). A doctoral dissertation experimental study (Christoff, 2003) of the original Be Set Free Fast procedure, which involves a 4-point tapping routine that is combined with statements regarding elimination of emotional distress, suggested that this approach is effective in the treatment of insect phobia. Another EFT study focused on subjects who had been involved in motor vehicle accidents and who experienced posttraumatic stress associated with the accident (Swingle, Pulos, & Swingle, 2004). All subjects received two treatment sessions and all reported improvement immediately following treatment. Brain-wave assessments before and after treatment indicated that subjects who sustained the benefit of the treatments had increased 13-15 Hz amplitude over the sensory motor cortex, decreased right frontal cortex arousal, and increased 3-7 Hz / 16-25 Hz ratio in the occipital region.

Waite and Holder (2003) conducted a study of EFT for phobias and other fears with 119 university students (nonclinical population). An independent four-group design was used, and subjects were treated in group settings. The treatment conditions included EFT, placebo (tapping sham points on the arms), modeling (tapping the acupoints on a doll), and no treatment controls. Although the difference between EFT and control groups did not reach significance, a statistically significant decrease in SUD at posttreatment occurred with all three groups. Discomfort ratings decreased from baseline to posttreatment for the EFT ($p = .003$), placebo ($p < 001$), and doll tapping ($p < .001$) groups, but not for controls ($p = .255$). Although the authors suggested that the effects of EFT are related to systematic desensitization and distraction, a review of their results by Baker, Putilin, and Carrington (2008) drew quite different conclusions. It noted that the placebo and modeling groups also involved simultaneous physical stimulation, treatment for psychological reversal, a simplified collarbone breathing exercise, reminder phrases, the "nine gamut" protocol of EFT, and tapping with the fingertips, which include several of the meridian endpoints specified in EFT.

A recent study sponsored by the National Institutes of Health (Elder et al., 2007) found that the Tapas Acupressure Technique (TAT) was significantly more effective at helping people maintain their weight after dieting than were qigong and a self-directed support group. The researchers concluded that TAT offered an easy-to-use approach that was not time consuming, whereas qigong might have been more difficult and time consuming. Additionally, a synopsis of patient interview data suggested that TAT was helpful in curbing food cravings, controlling overeating, and managing stress.

A pilot study examined the effects of energy psychology on claustrophobia with four claustrophobic subjects and four non claustrophobic controls (Lambrou, Pratt, Chevalier, & Nicosia, 2001). All subjects were evaluated with pencil-and-paper

tests, biofeedback measures, and subjective and behavioral measures before and after treatment and at approximately 2-week follow-up. A unique feature of this study is that the electrical properties in the acupuncture system were measured. Statistical analysis revealed significant differences before and after treatment between the control group and the claustrophobic group. The researchers noted that the measures of autonomic functions included in the study are less susceptible to placebo or positive expectancy effects.

The most extensive preliminary clinical study on the effectiveness of energy psychology was conducted in South America over 14 years with 31,400 patients (Andrade & Feinstein, 2004). A substudy of this group took place over 5.5 years with 5,000 patients diagnosed with PTSD and many other psychological disorders. Included in the substudy were only those conditions in which energy psychology and a standard of care control group (cognitive-behavioral therapy, plus medication when indicated) could be used. At the end of treatment and at follow-up periods of 1 month, 3 months, 3 months, and 12 months, the patients were interviewed by telephone by interviewers who had not been involved in the patients' treatment. These follow-up interviews revealed a 90% positive clinical response and a 76% complete elimination of symptoms with energy psychology alone, and a 63% positive response and a 51% complete elimination of symptoms with CBT/medication ($p < .01$). These results are significant, indicating that energy psychology was superior to CBT/medication for a wide range of psychological disorders. Furthermore, while the average number of sessions in the CBT/medication group was 15, the average number in the energy psychology group was only three.

The studies that used EP energy psychology as a treatment for PSTD are particularly interesting, as PTSD is considered a treatment-resistant and refractory condition. Some reviewers have even argued that it may be incurable and should be regarded as a condition that can be, at best, managed (Johnson, Fontana, Lubin, Corn, & Rosenheck, 2004). Yet in several studies, energy psychologyhas successfully brought PTSD scores from clinical to subclinical levels. In a within-subjects study, Sakai (2007) used TFT with a population of genocide orphans in Rwanda and found statistically significant reductions in symptoms in a single session. In a second uncontrolled trial, Stone, Leyden, and Fellows (2009) found reductions in PTSD symptoms in genocide survivors in a different Rwandan orphanage, using two group sessions plus a single individual session with the most traumatized individuals. Church, Piña, et al. (2009) performed an RCT with 16 abused male children aged 12 to 17 in a group home. The experimental group of eight received EFT, whereas the control group of eight received no treatment. A 1-month follow-up was performed, which found that the PTSD levels of all eight of the EFT group had normalized, whereas no member of the control group had improved ($p < 001$).

EFT has been used to successfully reduce PTSD symptoms in two pilot studies with war veterans (Church, 2009b; Church, Geronilla, & Dinter, 2009). In the first study, 11 veterans and their family members received a week-long EFT intensive consisting of 10 to 15 sessions. Their average scores dropped from clinical to subclinical levels, as did their other psychological symptoms, such as hostility, psychoticism, phobic anxiety, and depression. Three follow-ups, including at 1 year, found them stable, having maintained the gains they experienced in the intensive workshop. In the second study, veterans received six sessions of EFT, with similar results. These studies led to a full RCT with a much larger group of subjects (Church, Hawk, et al., 2009). The results from this study again showed that symptoms in a wait list control group did not diminish over time, whereas six sessions of EFT produced drops to subclinical levels of PTSD, with the average subject remaining at subclinical levels at 3- and 6-month follow-up. By comparison, a very similar PTSD study of a conventional talk therapy approach, using cognitive CBT, showed that only 40% of veterans improved after treatment, and 60% did not improve (Monson et al., 2006).

Brattberg (2008) performed an RCT with fibromyalgia sufferers, with EFT delivered entirely online. She found that pain, muscular soreness, and other fibromyalgia symptoms improved markedly and to a statistically significant degree with those in the EFT group. Together with the studies showing improvements in pain and cravings (Church & Brooks, in press), these results indicate that EP may improve not just psychological symptoms but physical ones too.

Two RCTs measuring test anxiety in students have been performed. The first measured EFT,

Wholistic Hybrid of EFT and EMDR (WHEE), and CBT in university students (Benor, Ledger, Toussaint, Hett, & Zaccaro, 2009). It found that both WHEE and EFT improved test anxiety in two sessions, whereas CBT required five sessions. The second RCT examined test anxiety in high school students (Sezgin & Özcan, 2009). It compared EFT to progressive muscular relaxation (PMR), an effective relaxation technique that is often used in psychotherapy, using a single session, plus homework. The group receiving EFT had significantly less test anxiety on follow-up than did the PMR group.

While most studies have examined participants who are sick, one RCT examined the effect of EFT in a healthy population (Church, 2009a). Subjects were championship basketball players at an elite university team. They were assessed on the number of free throws they could successfully perform and on their jump height. They were then divided into two performance-matched groups. One received 15 min of EFT and the other a placebo intervention. On retest, the EFT group jumped slightly higher, but the results were not statistically significant. However, the EFT group performed 38% better ($p < .05$) on free throws after treatment. This indicates that the same EP techniques that can improve physical and psychological problems can also boost the performance of healthy peak performers.

This large and growing body of evidence for the efficacy of energy psychology for a wide variety of physical and psychological complaints and often in a very limited number of sessions, indicates to open-minded mental health professionals that these therapies offer a power and scope of intervention that no known psychotherapeutic methods can match. Integrating these methods into conventional talk therapies can speed up the process of resolving client problems, as well as provide clients with an affect-reduction technique that they can safely use between sessions.

Eye Movement Therapies

Eye movement integration (Andreas & Andreas, 1995), rapid eye technology (Johnson, 1994), EMDR (Shapiro, 1995), and one-eye techniques (Cook & Bradshaw, 1999) are eye movement therapies that have been found to be effective in the treatment of trauma and a number of other conditions. Essentially these methods have the patient access a trauma or other emotionally charged issue while moving his or her eyes bilaterally in various patterns. Eden reports that "versions of this technique have been passed down in various cultures for thousands of years" (Eden &Feinstein, 1998, p. 330). While Shapiro (1995) proposed an information-processing model to account for the effectiveness of EMDR, other researchers and theoreticians have offered energetic hypotheses to account for their mechanism of action (Gallo, 2002, 2005). Although eye movement methods possibly promote cerebral hemisphere balance to treat the presenting problem, an interrelationship of cerebral hemispheres, meridians, and psychological problems was previously observed by Diamond (1985) and is also utilized in AEP.

It should be noted that many of the results obtained with bilateral eye movements are also achievable with bilateral tapping on shoulders or hands and alternating finger snapping adjacent to both ears (Shapiro, 1995). Additionally, Johnson (1994) has explored the therapeutic effects of light, sound, color, and eye blinking. It should be further noted that quality training in these therapies is imperative, as severe abreaction frequently occurs even in the hands of the most skilled practitioner. Considerable research has supported the effectiveness of eye movement therapies, specifically EMDR (Shapiro, 1995).

Negative Affect Erasing Method, Causal Diagnosis, and Trauma

Many meridian-based approaches are highly effective and efficient in treating psychological trauma, especially trauma from the accidents or injuries that often trigger chronic rehabilitation conditions. The negative affect erasing method (NAEM), which I developed, has been found especially safe and effective in this regard. When providing NAEM, the therapist asks the patient to briefly think about the trauma (or other emotionally charged issue) and then tap on or otherwise stimulate the following treatment points: governing vessel-24.5 (the third eye point on the forehead between the eyebrows), governing vessel-26 (under the nose), conception vessel-24 (under the bottom lip), and governing vessel-20 (on the upper sternum). After each round of tapping, the patient re-evaluates the SUD. In most instances, I have found that several rounds of NAEM will resolve most single-incident traumas. For highly complex

and multiple traumas, NAEM is used to treat the various components involved. NAEM is often usefully combined with simple cognitive procedures, such as the instillation of positive outcomes and beliefs (Gallo, 2000).

Case 1: PTSD—Automobile Accident

A 19-year-old female college student was referred to me because of PTSD as a result of an automobile accident. The driver in the other car crossed the median and struck her vehicle head-on, killing himself and his passengers. My patient was pinned under the dashboard for several hours while a rescue team used the "jaws of life" to free her from her car. She suffered fractures to her ankles, an arm and shoulder, and also had back injuries. She had been experiencing frequent nightmares, flashbacks, panic, generalized anxiety, and guilt feelings and anger related to this event. In an effort to cope, she was frequently abusing alcohol.

Initially, we chose to focus on the incident of being pinned under the dashboard. After she thought about the incident and rated the SUD level as a 9, I asked her to dismiss the memory from consciousness while following the NAEM protocol and intermittently reassessing the SUD level. Rather than assuming the necessity of exposure to promote desensitization, NAEM and many other meridian-based therapies do not require this. It is not the abreaction that promotes therapeutic results. After about five rounds of NAEM, she was able to think about the event without experiencing distress. Follow-up sessions at 1 week, 2 weeks, and 2 months revealed that after the initial session, nightmares and flashbacks no longer occurred. Additionally, if she was asked to think about the event, she no longer experienced distress.

During the course of treatment, other aspects of the trauma were treated, including feelings of anger and guilt that she experienced concerning the people who died. That distress was also successfully resolved in one session.

During intake she also revealed that a relative frequently molested her from age 5 to 12. After successfully treating the vehicular trauma, we treated several of her distressing memories of being molested. These were easily resolved by employing NAEM and a more specifically focused EDxTM diagnostic-treatment protocol involving manual muscle testing (Gallo, 2000). Even after treating the memories that she was conscious of, she reported a lingering feeling of being "dirty and disgusting," which she reported as being localized in the vicinity of the lower abdomen. Employing an EDxTM diagnostic-treatment protocol, we were able to alleviate these sensations in a single session as well. A follow-up visit several months later revealed ongoing relief of this and other issues treated with these modalities.

It is commonly accepted among psychotherapists that psychological trauma results in a variety of psychiatric problems and can also lead to physical disease and interfere with physical and psychological healing. Such was the case with this patient, as well as with other patients that I have treated. Resolution of the psychological trauma yielded many benefits, including alleviation of intrusive thoughts, flashbacks, and nightmares of the trauma, as well as resolution of clinical depression and a tendency for her to abuse alcohol. Additionally, of interest to rehabilitation professionals, resolution of trauma through these efficient techniques enhanced the patient's physical rehabilitation, as she was no longer plagued with trauma symptoms that tended to be activated during the course of her physical therapy and other rehabilitative efforts. This PTSD work facilitated this overall rehabilitative process.

Chronic Pain Treatment

Although meridian-based therapies are used in the treatment of psychological problems, these methods are also useful in the treatment of physical pain, as the above studies indicate. In addition to relieving negative emotions and physical tension associated with the patient's pain condition, meridian-based therapy can be used to alleviate, reduce, and control pain symptoms themselves. I have found this particularly useful in treating headaches and migraines in addition to pain of the lower back, neck, shoulders, knees, and heels.

When treating pain, I have the patient rate the pain level on a 0–10 scale and observe various features of the physical symptoms while tapping on specific acupoints. For example, a headache sufferer would be asked to describe changes in the intensity, location, shape, color, and other dimensions of the pain while stimulating triple energizer-3 (TE-3), large intestine-4 (LI-4), or whatever treatment points are discerned via energy diagnostics. In many instances NAEM alone,

or in combination with other treatment points, has been found useful in effectively treating many pain conditions. However, it should be noted that TE-3 (on the dorsal side of the hand, between and approximately 1 in. above the little and ring finger knuckles in the direction of the wrist) and LI-4 (on the dorsal side of either hand between the thumb and index fingers at the midpoint of the radial margin of the second metacarpal bone) are particularly potent points for various pain conditions.

Case 2: Failed Back Syndrome

A middle-aged female patient entered treatment because of incessant nail biting, which also occurred nocturnally. History revealed that she had a chronic back pain condition and had undergone four back surgeries, including laminectomies and a fusion. The latter also resulted in pain at the location of her right donor hip.

She reported the pain level at the time of the initial session as being an 8 on a 10-point scale. She indicated that she had not experienced appreciable relief from oral pain medications, injections, physical therapy, or the like. Although the patient initially requested hypnosis to help her with the nail biting, I questioned whether possibly the incessant pain contributed to the nail-biting problem. Therefore, I suggested that we attempt to reduce her pain and that this might eliminate the nail biting as well. She agreed.

Employing standard AEP diagnostic procedures, I found that she was not psychologically reversed for alleviating the pain. Diagnostics also suggested that treatment of the triple energizer and kidney meridians would help to treat the problem. Initially, I had her visually observe the pain symptoms three dimensionally and report ongoing changes in the pain's location, dimensions, color, and weight while she tapped on specific acupoints.I directed her to tap on the TE-3 acupoint (between the little finger and ring finger knuckles on the back of her hand), alternating this with stimulating the kidney meridian K-27 (under either collarbone next to the sternum). Over the course of 10 min, the patient's physical symptoms dissipated, and she reported a "warm tingling" at the base of her spine. She was able to move about and bend without experiencing pain. This session resulted in pain relief for approximately 5 hr. At follow-up, the pain was successfully alleviated, and she was educated in detail about how to repeat the treatment procedure herself. Over time she experienced increasing periods of relief from the pain, with little need for medication. She was able to discontinue the use of a cane and found that she could walk distances comfortably. Also shortly after beginning treatment, she quit biting her nails. In all, treatment involved five sessions. Interestingly, about a month and a half after treatment concluded, she came to my office sporting her beautifully manicured fingernails.

Another chronic back pain patient had a history of coronary artery disease and suffered from chronic angina. After diagnosing a meridian-based treatment regime that alleviated the back pain for 4 to 5 hours after each application, I found that the patient's pain relief lasted the entire day within a few months of regular treatment. Interestingly, his episodes of angina significantly decreased and eventually remitted, making it possible for him to discontinue use of nitroglycerin patches.

Meridian-Based Therapy and Rehabilitation

Meridian-based therapy is useful for many issues that are of interest to rehabilitation personnel. When a patient is experiencing psychological distress related to a trauma, this can interfere with other aspects of treatment. For example, vigorous exercise or physical therapy can trigger flashbacks in PTSD patients. Emotional distress can create muscle tension, which can aggravate muscle functioning and block optimal benefits from physical therapy. Similarly, when a patient has been given an unfavorable diagnosis and told of the need for surgery or other medical procedures, this can be so traumatic as to interfere with the patient's cooperation and motivation for treatment. Also diagnostic procedures such as MRI's or nerve blocks pose a problem with claustrophobic or needle-phobic patients, and meridian-based techniques can be employed to rapidly alleviate such phobic responses. Additionally, general compliance with treatment is a frequent problem, and meridian-based therapies can be employed to efficiently alleviate these obstacles.

Finally, let us not forget the welfare of rehabilitation professionals themselves. The stress of one's work can interfere with professional effectiveness as well as personal enjoyment. Self-treatment with various meridian-based protocols can prove of tre-

mendous benefit toward alleviating stress and preventing compassion fatigue, as the 216 participants in the Church and Brooks (in press) healthcare workers study discovered.

Theoretical Reflections

How can we account for the therapeutic results achieved by stimulating acupoints while attuning a psychological problem (or even physical pain)? Are the specific acupoints relevant, or does it not matter where we tap? What does the tapping or other forms of stimulation really do?

A myriad of explanations can be offered to account for the results with meridian-based therapies and other energetic approaches. *Placebo effect* is one suggested mechanism of action. But if acupoint stimulation produces the rapid, consistent, and profound results that many clinicians report, it would seem that placebo has little to do with it. Rather, something is being harnessed by these treatments that only occurs occasionally when a placebo is administered. After all, that "something" that occurs with placebo effect is not simply an illusion. Perhaps these therapies consistently activate the placebo effect, but then that would negate the essential definition of such a term.

Another explanation is that these methods and techniques simply *distract* the patient from psychological or physical distress. While some degree of distraction undoubtedly occurs, as it is frequently difficult to maintain focus on the emotional or physical sensations while tapping, this explanation appears to be insufficient when ongoing relief is experienced after the treatment has been completed. Could it be that the tapping results in ongoing distraction long after the tapping has ceased? Perhaps.

Cognitive restructuring is also a viable explanation, as changes in thought and perception regularly occur as a result of these treatments. However, it would seem that the cognitive shifts represent a secondary effect after the negative emotion has been relieved. Although a positive shift in cognition can serve to support and further actualize healthy psychological functioning, energetic treatments per se do not directly address cognition as the lever for change. Also while awareness of the associated thoughts and cognitive restructuring are useful in the treatment of pain patients, it is insufficient to account for the alleviation of nociceptive sensations that often occurs with this form of treatment. EDxTM protocols regularly incorporate the outcome projection procedure, a cognitive–energetic technique, to increase the probability of sustained treatment effects (Gallo, 2000).

In view of the fact that acupoints are being utilized with meridian-based therapies, possibly neurotransmitters such as *endogenous opioids* sometimes play a role in the treatment effects, similar to what has been proposed with acupuncture (Pomeranz, 1996). Although it is likely that peripheral nerve stimulation activates the central nervous system to release endorphins, this hardly discounts the involvement of energetic effects. The question of the relationship among specific problems, specific acupoints, and the release of specific neurochemicals remains. There appears to be a signaling mechanism associated with the acupuncture meridians that figures into such action.

My preferred theoretical explanation is that invariably a whole range of aspects is involved in psychological functioning, healthy or otherwise. While the brain, neurochemistry, and cognition are implicated in psychological problems, these conditions are also perpetuated energetically. I believe that the distinctions among energy, brain, chemistry, emotions, consciousness, cognition, and behavior are in some respects arbitrary but useful distinctions.

Psychological problems can be viewed as energetic informational structures similar to the electromagnetic configurations that adhere to audiotapes and computer hard drives. The nervous system electrochemically captures, stores, and replicates sensory information at various levels of abstraction—subtle energy, electromagnetic, chemical, brain physiology, emotion, cognition, linguistic, and external behavior. Since nature constructs complex structures from fractals, at a fundamental level psychological problems are energetic configurations or field structures. By destabilizing the energetic informational field, the system is prepared to transform into another, preferably healthier, structure. Stimulating acupoints while the field is attuned destabilizes it and removes or collapses those elements that trigger the chain of events that result in the psychological or other health problem. Before it can transform into another stabilized informational field, the field must be destabilized. Frequently simple pattern interruption and disruption via energy therapies are sufficient for the system to leap to a higher order of organization. At other times, it is useful to

instill or reinforce a healthier structure (Furman & Gallo, 2000; Gallo, 2000).

This informational field has also been referred to as a "thought field" (Callahan & Callahan, 1996). In this respect, a thought is literally a specific kind of field, having a physical reality. It is composed of electromagnetic features as well as subtle energetic markers that can activate emotions. When the field is attuned, these energetic markers are available for treatment. Concurrently, all of the other features of the problem are activated. This includes brain structures, neurochemistry, internal dialogue and other cognitive features, and various behaviors consistent with the state. The application of causal diagnostic procedures, which are germane to more sophisticated meridian-based therapies, makes it possible to elicit the thought field's structure.

For the most part, emotions are congenitally hardwired (Nathanson, 1992), with brain structures such as the thalamus and amygdala designed to produce the myriad of emotions. When a trauma or other distressing event occurs, the input is represented in multimodal sensory form. Simultaneously these emotion-producing brain structures become bonded to the visual, auditory, tactile, gustatory, olfactory, and motor information (respondent conditioning). A trauma gestalt is formed, fundamentally held together energetically. When the memory of the trauma is attuned, the entire informational network comprising the trauma is activated. While this structure is activated, tapping on key acupoints sends electromagnetic impulses into the energetic informational field, destabilizing it, collapsing the energetic markers, and severing the stimulus-response bond to the limbic system. Informational structures, similar to other systems, are maintained within a range of energy balance—too much or too little energy causes the structure to collapse. The tapping destabilizes the structure by diverting or overloading the adhesive energetic field. It now becomes possible to view the traumatic event calmly and to incorporate the calmness into a new, transformed gestalt. The memory is basically the same; the experience is transformed. The patient comes to view the event from a higher perspective, with neutrality or deeper positive feelings predominating. Mindfulness prevails.

I think that theoretical explanations along these lines are relevant with regard to any psychological problem, and they also account for the genesis of many, if not all, physical diseases. Fundamentally there is an energetic field structure at the basis of physical forms, whether that form constitutes psychological or more obvious physical phenomena. A vision of energy medicine may be diagnosis, treatment, and prevention of disease at the energetic level. Energy psychology and meridian-based therapies energetically address what has been historically referred to as psychological problems. I think that the distinction between mind and body will come to blur, and the fundamental oneness of mind and body will come into focus.

Energy psychology is a revolution in our understanding of psychological functioning and treatment of psychological problems. The astounding efficiency of this modality is tantamount to the developments in physics and cybernetics during the last century that have profoundly advanced technology and medicine. While viewing psychological functioning and treatment from cognitive and behavioral perspectives has proven beneficial, treatment fashioned from an understanding of the energetic substrate offers a fundamental understanding that will advance psychological and other medical practices exponentially. Perhaps energy psychology's focus on energy and energy fields resonates best with the scientific and medical principle offered by friar William of Ockham: *Entia non sunt multiplicand apraeter necessitatem*. No more things should be presumed to exist than are absolutely necessary.

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