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Note: Four tiers of energy psychology interventions were described in the original paper, including 1) immediate relief/stabilization, 2) extinguishing conditioned responses, 3) overcoming complex psychological problems, and 4) promoting optimal functioning. This excerpt introduces three established phases of disaster relief responses and ties the "four tiers" of energy psychology interventions into them.

Energy Psychology in Disaster Relief
An Updated Excerpt

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Calibrating Interventions to the Three Phases of Disaster Relief

Applications of energy psychology following a disaster must be calibrated to the unique needs and constraints of each individual and to an understanding of the kinds of intervention that are appropriate at various timeframes after the disaster. A seminal volume, *Interventions Following Mass Violence and Disasters: Strategies for Mental Health Practice* (Ritchie et al., 2007) includes chapters discussing principles for *immediate responses* to disaster (Ruzek, 2007; Ørner et al., 2007; Young, 2007), interventions *one to four weeks* after exposure to a trauma (Bryant & Litz, 2007), and longer-term interventions (Raphael & Wooding, 2007). Understanding how emotional needs change over time helps the practitioner know where to apply the four tiers of energy psychology interventions discussed above.

Immediate Responses to a Disaster. Beyond attending to basic needs such as safety, security, food, shelter, and medical problems directly following a disaster, psychological first aid is defined as "the use of pragmatic-oriented interventions delivered during the immediate-impact phase . . . to individuals who are experiencing acute stress reactions or who appear at risk for being able to regain sufficient functional equilibrium by themselves, with the intent of aiding adaptive coping and problem-solving" (Young, 2007, p. 134). Psychological first aid is meant to be administered within the context of a larger emergency response strategy that includes community-level assessments and responses to mental health and public health needs.

After establishing safety and providing basic support and mental health information relevant to the disaster, early mental health responses involve:

1) Interventions that address specific traumatic stressors

2) Interventions that reduce arousal

3) Directing survivors to additional resources through problem-solving and referral

Specific stressors may include the violent unexpected death of a loved one, witnessing grotesque injuries or death, and loss of critical resources, along with ongoing intrusive images and cognitive distortions that increase distress and maintain an exaggerated sense of threat. Arousal reduction interventions might include stress management techniques and resources; cognitive reframing techniques; and psychopharmacological interventions (Young, 2007).

Energy psychology is applicable at numerous points within this framework, with particular strengths, according to practitioner reports, in the areas of reducing arousal, subduing intrusive memories, stress management, and cognitive restructuring. Young (2007) cautions that psychological first aid following disasters "does not focus on emotional processing or detailed trauma narratives . . . and should only be used" with individuals who exhibit extreme acute distress reactions or notable risk factors associated with adverse post-disaster mental health outcomes (p. 135). Energy psychology practitioners who are experienced with providing immediate disaster responses tend, however, to be less conservative than Young (and the literature in general) in terms of suggested constraints on emotional processing and eliciting detailed trauma narratives because acupoint tapping is able to mitigate problematic reactions.

Jim McAninch, of Pittsburgh's Critical Incident Stress Management (CISM) team, has often been on the scene within hours following accidents that involve fatalities. The mandate of the CISM team includes facilitating "normal recovery process of normal people having normal, healthy reactions to abnormal events." Like most community disaster response programs, McAninch's team is explicitly not meant to provide psychotherapy or to substitute for psychotherapy, yet its stated goals include therapeutic objectives that would fall within the parameters of psychological first aid and other early mental health interventions. McAninch's administrative supervisor was at first highly skeptical about McAninch's desire to use TFT as part of the CISM disaster response. However, as McAninch's interventions were bringing about rapid and striking results in facilitating the emotional recovery of survivors of events involving fatalities, McAninch was asked to and has provided TFT training to the entire Pittsburgh CISM Team.

McAninch typically has those who were directly involved in the accident recount or mentally replay what they witnessed, sometimes one-on-one and sometimes with other witnesses and survivors. While focusing on difficult memories or feelings, the person is simultaneously tapping on acupoints that purportedly reduce arousal. In addition to processing the recent event, McAninch notes that, with the accidental deaths and injuries handled by his team, unresolved traumas from a survivor's past are often activated. Treating these, again by stimulating acupoints while the memory is actively engaged, helps the present traumatic incident, in McAninch's experience, to be more easily and rapidly resolved (reports in this paper of energy psychology applications following catastrophic events are based on interviews I conducted with the practitioner in person or via phone, Zoom, or via e-mail).

This use of a readily available technique that quickly decreases arousal is a critical difference between energy psychology and critical incident debriefing or other interventions that

might ask a person to recount a trauma within days after it occurred. Sophia Cayer, an EFT practitioner who worked with hurricane evacuees in Alabama following Hurricane Katrina explained: “The difference is that with EFT, even if it is only a single session, it doesn't leave the person stranded. It is not a matter of just soothing them and then letting them go. They are given powerful tools they can regularly use as they move through the crisis and beyond.”

For instance, Barbara Smith, a trauma specialist who worked for a government-funded agency in New Zealand, often took the official report of a person who had been recently traumatized. She needed the people she interviewed to recall and recount their traumatic experiences in detail to complete the necessary paperwork. Since some of them were still in deep shock from the recent incident or from earlier trauma that had been reactivated, and many reexperienced the horror and overwhelm of the traumatic event in talking about it, it might take up to four sessions to complete a single report. And even then, the reports might not always be clear or coherent. By simply introducing tapping and having her clients continuously tap specific acupoints while recounting their painful experiences, Smith found that “the time it takes to collect the crucial information is more than cut in half [and] the reports themselves are more coherent and accurate.” She added that as a side benefit, these trauma victims “learn how to calm themselves from the very first session” (this story was related to me by psychologist Patricia Carrington, a pioneer in the development EFT).

Smith’s use of acupoint tapping is consistent with the way other practitioners report applying it within the first days or weeks following a trauma. While aggressive probing or invasive uncovering techniques are generally not used by energy psychology practitioners immediately following a disaster, acupoint tapping is often applied to memories and thoughts the client is already expressing or actively ruminating upon. Rather than utilizing a complete energy psychology protocol, the tapping techniques that are most effective for reducing arousal are taught on a psychological first aid basis (our First Tier—Immediate Relief/Stabilization).

These techniques can be introduced in a simple and matter-of-fact manner. Young (2007, p. 143) provides a 30-second approach for introducing diaphragmatic breathing, gently using words such as: “Everyone feels overwhelmed now, how about we take a few slow deep breaths” [along with a demonstration of diaphragmatic breathing]. This could be followed by suggesting, “Let’s add to this now some tapping on stress release points. Just tap where I tap.” Intrusive images, previous memories activated by the trauma, and the affect produced by cognitive distortions may also be the focus while points that reduce arousal are tapped (Second Tier—Extinguishing Conditioned Responses). Demonstrating how to self-stimulate acupoints that reduce arousal provides a straightforward tool for emotional self-management that, according to reports from energy psychology practitioners, is quick, effective, and generally as safe as other relaxation techniques.

Still valid, of course, are concerns about retraumatizing a disaster survivor who is beginning to stabilize, about undermining the individual’s natural coping strategies, and about inducing the person to process the trauma prematurely when a period of denial would allow the person to rest and regroup. Young (2007) also noted that in rare cases, any form of relaxation technique may increase anxiety, intrusive images, or dissociative states. Because tapping acupoints, when properly introduced and applied, is relatively noninvasive, even if it does not

produce the desired effects, no harm is done by the physical procedure as such, and unexpected reactions can be mitigated by further tapping. Summarizing his experiences as a member of the TFT Trauma Relief Committee providing post-disaster energy psychology services in Kosovo, Rwanda, the Congo, and New Orleans, Paul Oas, Ph.D., told me, "Safety, food, and shelter come before emotional healing, but even under dire circumstances, you can use the tapping procedures to calm people who are hysterical." As with any other early mental health intervention, sensitive clinical judgment, and an awareness of the known hazards of well-meaning early responses are of course critical ingredients for an effective intervention.

Interventions One to Four Weeks after Exposure to a Trauma. After the initial phase of shock and disorientation, mental health interventions between one and four weeks following a disaster have different goals "and employ different strategies than responses that typically occur in the initial days after trauma exposure" (Bryant & Litz, 2007). While managing stress reactions is still a prominent concern, the focus shifts to identifying individuals who are at greatest risk of chronic mental health problems and deciding how to use inevitably scarce mental health resources most effectively.

It may not be possible to make accurate distinctions about which survivors are vulnerable to chronic mental health disorders within the first week after a disaster. A degree of anxiety and other elevated emotions may be normal and healthy responses that can motivate appropriate coping behavior. Acute Stress Disorder (ASD) was first introduced into the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (Fifth edition, 2013) in 1994 for diagnosing symptoms such as pronounced anxiety or arousal, intrusive thoughts or flashbacks, acute dissociation, marked avoidance, and other sequela to trauma that may occur two days to four weeks following exposure to an extreme stressor. This same symptom cluster, if it persists for more than a month, overlaps with the criteria for PTSD. Approximately 80 percent of people who exhibit symptoms of ASD during the first month following a catastrophic event will develop PTSD (National Center for PTSD, 2019).

Also somewhat complex to interpret is the data on when to offer intensive treatment. While existing studies of energy psychology do not offer insight into this question, early CBT studies do. Studies of trauma survivors (reviewed by Bryant & Litz, 2007), suggest that four to six two-hour sessions of CBT applied two to four weeks following a trauma greatly reduces subsequent incidence of PTSD. For example, in one well-designed investigation, 67 percent of a supportive counseling control group met the diagnostic criteria for PTSD at six-month follow-up compared to only 20 percent in the CBT group. Bryant and Litz also note that if it is not possible to apply CBT within the first few weeks of a trauma due to limited clinical resources or excessive demands on the trauma survivor, therapy for PTSD is still likely to be effective at a later point. They caution, however, that supportive counseling rather than active psychotherapy during the first few weeks following a trauma may be indicated for individuals exhibiting severe dissociative reactions, severe substance abuse or dependence, severe ongoing stressors, unresolved prior trauma, or significant suicide threat.

Energy psychology treatments in the weeks following a trauma can continue to focus on lowering anxiety levels, countering intrusive thoughts and images, and addressing troublesome affect and cognitive distortions (First Tier—Immediate Relief and Stabilization) as well as

attenuating reactions to innocuous triggers (Second Tier—Extinguishing Conditioned Responses). Because of the relative speed of response when acupoint tapping is applied to these issues, Third Tier interventions (Overcoming Complex Psychological Problems) may also be introduced as appropriate in the first four weeks. Because disaster relief teams are often deployed for only a limited period, the availability of follow-up or referral resources is a consideration before pursuing long-term issues.

Interventions after the First Month. Raphael and Wooding (2007) describe a "honeymoon period" shortly after a disaster, during which there is intense affiliative behavior, convergence of support, and public acknowledgement of heroism and suffering." This phase may, however, over time "merge into angry protest and disillusionment and demoralization, then progressive recovery and renewal" (p. 175). By a month following the disaster, "the impact of loss of human life, injury, and destruction of physical and social resources should be fairly clearly defined" (p. 177). Individuals who may be in need of longer-term treatment can be identified. Particularly vulnerable are those who are bereaved, injured, whose acute stress symptoms persist, who were most severely exposed to the disaster, whose physical and social resources have been destroyed, who have been previously traumatized, who had preexisting mental illness or physical disabilities, and who served as emergency responders.

Long-term treatment that begins in the aftermath of a catastrophic event typically involves more than healing traumatic memories, reducing hyperarousal, and transforming negative beliefs. Energy psychology practitioners who have provided services in violent regions reported during our interviews that decreasing the arousal to the most horrific memories of warfare and genocide not only produced overall improvements in the survivor's ability to function; it also allowed deeper psychotherapeutic exploration. Lifelong psychological and behavioral patterns may be examined, relationships may be transformed, and social involvements may radically shift during the reorientation process that follows the destabilization caused by severe trauma. As opportunities allow, energy psychology may also be readily combined with other methods, such as depth psychotherapy (Mollon, 2008), in addressing the demanding psychological struggles many people face following a severe traumatic experience (Third Tier—Overcoming Complex Psychological Problems).

As these challenges are addressed, "post-traumatic growth" may result in greater resilience and inner peace than prior to the catastrophic event. A study of the longterm impact of the most traumatic life experiences of 83 "elders" (average age of 77.9) suggested that "posttraumatic growth from events that occurred even many years earlier may have favorable influences on subsequent coping, death attitudes, and adjustment to recent stressors" (Park et al., 2005, p. 297). While this appears to be a natural adaptation that frequently occurs, energy psychology can further facilitate it by isolating and tapping on desired outcomes such as resilience, confidence, and courage. By supporting post-traumatic growth, the trauma survivor may wind up functioning at a higher level than prior to the trauma (Fourth Tier—Promoting Optimal Functioning).

Larger existential questions may also need to be addressed, such as "Why did I survive?" when loved ones or others were lost. As Shalev (2007) noted, it is the desire for life that ultimately motivates survivors—whose shock, despair, and depression may be overwhelming—

to move on. Shalev explains, “We regularly address survivors’ negativism, hoping that once the grip of such emotions loosens, the desire for life will put the trauma back into its right place as interference with life rather than life-defeating occurrence” (p. 118).

Completion. A pioneer in applying Thought Field Therapy) in post-disaster settings has been Carl Johnson. Johnson, an ABPP level clinical psychologist, retired from a career as a PTSD specialist with the Veteran’s Administration. He learned TFT toward the end of his time at the V.A. He found TFT to be far more effective than the tools that had previously been at his disposal. I had the privilege of interviewing Dr Johnson extensively while writing this paper. At the time of our interviews in 2005, he had for nearly two decades regularly traveled to the sites of some of the world’s most terrible atrocities and disasters to provide psychological support using TFT. When I asked him how he determines if a treatment for a traumatic event has been successful, he replied:

> It has been successful when there is no suffering or anguish upon recalling the event. But at the same time, there is no reduction in sensitivity, distortion of values, or impairment in the ability to love. The memory is retained, but it is no longer in neon. There is still an awareness of the horror of the event, but it no longer has its grip on the person’s soul. Where the memory had controlled the person, now the person has control of the memory.

Case History

This excerpt will close with one of the many stories relayed to me during my talks with Dr. Johnson. About a year after NATO put an end to the systematic campaign of terror, murders, rapes, and arson in Kosovo between March 5, 1998**,** and June 11, 1999, Johnson found himself in a trailer in a small village where the brutalities had been particularly severe. A local physician who had offered to refer people in his village had posted a sign that free treatments for war-related trauma (listing nightmares, insomnia, intrusive memories, inability to concentrate, etc.) were being offered. Johnson described how, as a line of people had formed outside of the trailer, the referring physician told him, with some concern, that everyone in the village was afraid of one of the men who was waiting outside for treatment.

The others in the line had actually positioned themselves as far away from this man as possible. Johnson asked the physician to invite the man into the trailer. Johnson, who after a career in the V.A. was seasoned in working with war veterans, recalled that the man “had a vicious look; he felt dangerous.” But he had come for help, so with the physician translating, Johnson asked the man to bring to mind his most difficult memory from the war. Everyone in the village was haunted by traumas of unspeakable proportion: torture, rape, witnessing the massacre of loved ones. As the man brought the trauma to mind, his face tensed and reddened and his breathing quickened. Though he never put his memory into words, the treatment began.

Johnson tapped on specific acupoints that he determined to be relevant to the trauma. He then instructed the man, through the interpreter, to do a number of eye movements and other simple physical activities designed to accelerate the process. Then more tapping. Within fifteen minutes, according to Johnson, the man’s demeanor had changed completely. His face had relaxed and his breathing normalized. He no longer looked vicious. In fact, he was openly

expressing joy and relief. He initiated hugs with both Johnson and the physician. Then, still grinning, he abruptly walked outside, jumped into his car and roared away, as everyone watched perplexed.

The man's wife was also in the group waiting for treatment. In addition to the suffering she had faced during the war, she had become a victim of her husband's rage. The traumas she identified also responded rapidly to the tapping treatment. About the time her treatment was completed, her husband's car roared back to the waiting area. He came in with a bag of nuts and a bag of peaches, both from his home, as unsolicited payment for his treatment. He was profuse in his thanks, actually appearing gleeful, indicating that he felt something deep and toxic had been healed. He hugged his wife. Then, extraordinarily, he offered to escort Johnson into the hills to find trauma victims who were still in hiding, too damaged to return to life in their villages, both his own people—ethnic Albanians—and the enemy Serbs.

In Johnson's words, "That afternoon, before our very eyes, we saw this vicious man, filled with hate, become a loving man of peace and mercy." Johnson further reflected how often this would occur—that when these traumatized survivors were able to gain emotional resolution on experiences that had been haunting them, they became markedly more loving and creative. While survivors, even after a breakthrough session like this, are still left with the formidable task of rebuilding their lives, the treatment disengaged the intense limbic response from cues and memories tied to the disaster, freeing them to move forward more adaptively.

The 105 people treated during Johnson's first five visits to Kosovo, all in 2000, had each been suffering for longer than a year from the post-traumatic emotional effects of 249 discrete, horrific self-identified incidents. For 247 of those 249 memories, the treatments (using TFT) successfully reduced the reported degree of emotional distress not just to a manageable level but to a "no distress" level, "0" on the standard 0-to-10 "Subjective Units of Distress" or SUD scale (after Wolpe, 1958), as reported by those receiving the treatments.

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