Tap Roots and the New Normal: Getting to the Bottom of Energy Psychology

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Barker, Kober, Hoerauif, Latzke, Adel, Kain, and Wang (2006) studied whether acupressure can decrease anxiety and pain in older adults with acute hip fracture and found significance at p-value of 0.0001! In addition, Thought Field Therapy (TFT), a type of Energy Psychology, has rendered a 97% success rate in studies by both Callahan (1987) and Leonoff (1995) in Gallo (2005, p. 193). Furthermore, Johnson, C., Shala, M., Sejdijaj, X, Odell, R. and Dabishevci, K, (2001) helped 103 of 105 patients with severe, very gross trauma in Kosovo. So what is EP and what makes it draw such controversy? Can it help patients with co-occurring negative affect and pain? This article will explore basic theoretical (context and research) ideas and practical issues (why it works, major practical contributions, and controversies) of Energy Psychology (EP). In addition, this article will mention pain and related negative affect whenever possible and in terms of treatment with EP.

This article will begin with some operationalizing of terms and give a brief discussion of context. First, EP is "branch of psychology that studies the effects of energy systems on emotions and behavior." (Gallo, 1999, p. xi, in Mason 2012). According to the ancient Chinese, the meridians in the human body refer to "an energy system that follows a specific pathway," (Gallo, 2005, p. 31). Units of Distress Scale (SUDS) is used for clinical reasons so that patients can communicate the levels of distress. Dual diagnosis will refer to where "negative affects" co-occurs with pain. FFF denotes the flight or fight or freeze response and ACEP refers to the Association for Comprehensive Energy Psychology.

For context, it is important to note that this article will assume the bio psychosocial model of health first proposed by Engel (1977). This integrates the medical and physical aspects of pain with the cognitive, emotional, and behavioral issues of pain (Gatchel, Peng, Peters, 2007). Two important researchers, Melzack and Wall, "argued that psychological factors and environment play a large role,

and that pain is subjective and ultimately at the mercy of the brain" (Shainblum, 2014). William Tiller's work alludes to the bio psychosocial spiritual context.

The first step, in looking at EP, is to mention that there is ample research in terms of co-occurring pain and negative affect. For example, "The association between depression and pain in older adults has been demonstrated consistently," (Karp and Reynolds, 2009, p. 17. For more examples of research on pain and mood disorders, see Table 1). In terms of research literature on EP itself, much is available as well. Feinstein (2008) reports that "The World Health Organization (WHO, 2002) lists 28 conditions where scientific studies strongly support acupuncture's efficacy and 63 more conditions for which therapeutic effects have been observed but not scientifically established" (http://www.innersource.net) again, including pain and dual diagnosis. Feinstein (2008) further notes he has located "389 reports on emofree.com for physical pain (which often has an emotional component)" (parentheses his, http://www.innersource.net). Likewise, Feinstein (2008) reported that Harvard Medical School's Consumer Health Information website reviewed "420 articles" and found "at least preliminary evidence for the efficacy of acupressure… such as anxiety, depression…" (http://www.innersource.net) and others, including pain. Andrade and Feinstein (2003, in Gallo, 2005) studied 5000 patients during a five year period and found that "90% had a positive clinical response and 76% complete remission of (various) symptoms in the group with tapping alone" with the p-value 0.01 (p. 198). The ACEP offers on its web page approximately three dozen Randomized Controlled Trials with Potentially Strong Generalizability http://www.energypsych.org, see Table 2 for other studies).

In fact some studies use a specific type of EP, often EFT (Emotional Freedom Technique). This writer's personal favorite study is anecdotal but somewhat unique and well worth mentioning. McCarty (2006) has reported in a medicine journal, "successful treatment of a six-year old boy's lifelong eating phobia using a surrogate person for his treatment with EFT (that is, without the child being present!)"

(parenthesis hers, p. 117). In fact, Church (2013, p. 647) writes, "Studies of EFT for physical symptoms include a range of experimental designs." Bougea, Spandideas, Alexopoulos, Thomaides, Chrousos and Darviri (2013) found that EFT decreased salivary cortisol levels and the frequency and intensity of headache episodes and reduced stress. More germane, Dr. Brattberg (2008) an MD in Sweden, reported he used self-administered EFT to improve, "pain, anxiety, depression, vitality, social function, mental health, performance problems, involving work or other activities due to physical as well as emotional reasons and …pain catastrophizing measures" (p. 32). Although the N size was small and the dropout rate high, the results indicated statistical significance for improvement in patients by the program of self-administered EFT. In a 2010 study by Church and Brooks, they also used self-administered EFT to reduce healthcare worker's stress, cravings, and physical pain. Here subjects reported a 68% drop in physical pain. The study reached significance at the immediate time of the study and retained it in measures taken 90 days later. Also, Veterans found relief from pain using EP (in addition to the many studies of Vets receiving EP for PTSD, i.e. Church, 2009). "Veterans were found to experience significant drops in physical pain after (treatment with) EFT" (Swack, 2009). However, EFT was not the only type of EP studied. For example, at least "five studies supporting the effectiveness of Thought Field Therapy (TFT) have been reported for the treatment of phobias and other anxieties," (Gallo, 2005, p. 106).

Next, this article will explore three practical issues of (EP): its major contributions to both the literature and to the practice of EP, some salient technical issues of EP (why it works), and state a few of the controversies within EP**.** The six greatest contributions of EP are its reduction of both suffering and cost; prevention of negative affect and related issues of pain; its non-shaming techniques for resistance; its attention to and development of the best environmental conditions for muscle testing, and its minimal re-traumatization. In terms of epidemiology, in a "sample of 1,801 older primary care patients, Unutzer

et al found that 79% reported functional impairment from pain within the previous month" (Karp and Reynolds, 2009, p. 24). In the US, pain related costs in 2010 climbed to $216 to $300 billion for 2010 (Gaskin and Richard, 2011). Furthermore, with the American baby-boomers coming of age in droves, many will be affected by chronic pain bringing high numbers of sufferers and high societal costs. Just the fact that it usually only takes a few sessions to achieve a goal, obviously lowers the individual cost of treatment.

Not only does EP treat negative affect when it is the only pathology but EP may prevent mental illnesses from forming through its pain reduction properties. According to the Harvard News Letter, "People with chronic pain have three times the average risk of developing psychiatric symptoms… and depressed patients have three times the average risk of developing chronic pain" (http://www.health.harvard.edu). Depression and pain "are mutually exacerbating and disabling…(and) are risk factors for the onset of each other" (Karp and Reynolds, 2009, p.17). In addition, similar regions of the brain seem to be engaged in both depression and pain (Karp and Reynolds, 2009). The "pain-processing areas of the brain include the same areas seen in mood and anxiety disorders" (Karp and Reynolds, 2009, p. 19). In this bio psychosocial model with dual diagnosis, all feelings, negative or positive are "distributed throughout the body, produce chemical changes within the entire system" (Dale, 2009, p. 28). Dale (2009) reports "Negative emotions such as anger, frustration, or anxiety disturb the heart rhythm" (p. 28) giving emotion a physiology that can be treated, bringing the discussion back to biopsychosocial integration. Certainly one of the reasons for this co-occurrence could be similar bio psycho social profiles for dual diagnosis. For example, "self-efficacy and learned helplessness" are often found in both pain and depression (Karp and Reynolds, 2009, p. 19). Sutherland (allied with Dr. Andrade and both working in Australia) discussed the bio psychosocial context her book The Pain Train, (2006, http://www.bmsa-int.com) . She noted that pain was not relieved with

typical medical and allied medical therapies because: "…we did not (and most interventions still don't) understand the crucial role played by seemingly non-physical factors such as the patient's social, family, emotional, psychological, financial and occupational issues" (p. 11). Developing it a bit further, Feinstein (innersource.net) reports EP is a "valuable expansion of the traditional bio psychosocial model of psychology to include the dimension of energy."

Perhaps one of EP's most powerful contributions to the world of healing is its ability to easily, without shaming, deal with the concept of "unrecognized conflict" – that is, resistance. In fact, Turk and Monarch (2002) educated about that problem and specified that locating any conflict about accomplishing the goal should be a primary focus. In 2000, Gallo and Vincenzi developed NAEM negative affect erasing method for just that reason (Gallo 2005, p. 181). Gallo (2005) specifically says that the most important part of the NAEM is "the therapeutic results that it produces and only secondarily, any theoretical position that it supports" (p. 181) Perhaps out of all EP has to offer other therapies, the resistance techniques are some of the strongest in terms of providing what other therapies do not.

The next contribution discussed here is in the context of the treatment and has three points (context of muscle testing, intention and the ease of combining EP's with other paradigms). Muscle testing is a well-developed technique and here the therapist's accurately applied procedures are critical. The following are some of the known confounding conditions: smiling of the tester; tester bias and non-neutrality; inappropriate or poor muscle testing technique and dehydration of the patient. Further, muscle testing should move toward the patient's highest wisdom and be done under appropriate conditions, questions should not be non-verifiable like if there is life on Mars. Not only should the practitioner be clear and balanced in the beginning of testing, the patient should be assessed for having the poles reversed. The testing needs to be accurate and complete including back checks. Critical here, is

that an atmosphere of Intention is needed when using EP and this is the logical reason why 'not hitting the correct spot' for tapping can 'make it' work successfully regardless. Part of the actual intervention is the Intention. Lastly, much of EP can be used in conjunction with other approaches including CBT and/or motivation interviewing and/or Gestalt. Indeed, Turk and Monarch (2002 write, "EP interventions with complex problems may readily be (and often are) combined with other treatment approaches" (p. 138). Similarly, Clinton (2006), herself a Jungian, explains some of her techniques come pre-mixed with the other paradigms into protocols named as such, and writes, "in Seemorg the synthesis has already been made in the sense that it includes protocols that treat the psychodynamic, transpersonal, psychogenic physical, cognitive, behavioral" (p. 97) levels. The lack of abreaction is the last EP contribution to the field mentioned here. In the EP approach, the whole goal is to process traumatic memories without re-experiencing the emotional pain. Reviewed in the practical section has been the six greatest contributions of EP including its reduction of both human suffering and societal cost; reduction in dual diagnosis; its techniques for resistance; its attention to the best environmental conditions for muscle testing and its ability to address trauma without very much if any abreaction. Next, this article will address salient technical issues of EP.

In terms of suggestions about how EP works, this writer located six hypotheses. Bio psychosocial ideas of mind body (Gallo and Feinstein); Tiller's (biopsychosocial spiritual) matter and energy; Callahan's transduction of kinetic energy; new, general neurological brain research (explained by Feinstein); Ruden's and others ideas of correcting biochemistry; and empathy of therapist.

First, Feinstein (2008) offers the idea of EP as engaging for the patient as well as EP offering a sense of structure: "Energy psychology utilizes imaginal and narrative-generated exposure." Gallo (2009) writes "while psychological disturbance manifests psycho dynamically, behaviorally... (There is an) energy component that provides the instructions that catalyze the entire process" (p. 14). Second, Dr.

William Tiller, among his many gifts to subtle energies, hypothesized a relationship of the interaction between matter and energy which may be relevant here in EP healing via tapping meridians. That is, Tiller proposed that higher vibratory energies interact with lower energies in the body which may be affected by tapping. Third, Callahan's piezoelectric effect proposition of the way energy stimulates the meridians:

> "….tapping on the acupoints transduces kinetic energy into the meridian.. … this probably causes a piezoelectric effect….That is, since bone is crystallized calcium, the tapping generates a small amount of electrical current that enters or otherwise stimulates the meridian" (Gallo, 2005, p. 129).

The fourth reason EP works comes from new research in general neurology and psychology. Previously, consolidation, the process by which newly learned information is stored, was thought to take place only at the time of the original experience. New information on exposure treatment suggests otherwise. Beyond reducing hyperarousal in the moment, it appears that EP can assist the memory to be re-consolidated (remembered differently) on a case by case basis, back into the person's neurology and cognitive system (Garakani, Mathew, & Charney, 2006). The result is Feinstein's "new normal." In fact, a research program at New York University led by (writer) Joseph LeDoux has demonstrated that "consolidated memories, when reactivated through retrieval, become labile (susceptible to disruption) again and undergo reconsolidation" (parentheses theirs, Debiec, Doyere, Nader, & LeDoux, 2006, p. 3428).

Furthermore, "certain stimuli, such as pain, extreme physical stress, or intense emotional reaction register in the amygdala, and set off the FFF response. The amygdala learns to associate patterns of stimuli which have been paired with danger to set off the FFF response" (Lane, 2009, p. 4). Indeed, Feinstein, 2009 reports that "evoking anxiety-producing memories or cues while simultaneously sending

de-activating signals to the amygdala via acupoint stimulation prevents the memory or cue from triggering an anxious response" (p. 6). Feinstein (2009) proposed that the speed that EP works (one or a few sessions) may involve "mechanical explanations." In conclusion, Feinstein writes (2012, p. 76), "Three ways that energy psychology protocols impact the body's energies have been proposed," the results of which are referred to as the new normal:

> "(a) electrochemical impulses reduce arousal in the limbic system during the reconsolidation window, which allows neural pathways maintaining outdated emotional learnings to be revised or eliminated; (b) delta waves are generated, which are also involved in depotentiating maladaptive emotional learnings; and (c) balancing the body's meridian energies by stimulating acupoints brings greater order and coherence to the organizing fields that regulate neural activity."

Ruden (2010) along with others such as Swack (2001, hblu.org/) suggested another reason why EP appears to work: biochemistry. He thought that although the techniques are 'psychology' part of the success lies in its "involving the chemistry of the brain" (p. 201). For example, Andrade & Feinstein (2004) showed a significant change in neurotransmitter profiles from acupoint treatment. Dale (2009, p. 173) names Serotonin as "a mediator for acupuncture analgesic in both the brain and the spinal cord." In addition, although brain chemistry is important when discussing EP, it turns out to be crucial in the discussion of dual diagnosis. The National Institute of Health refers to a study by Bair, Robinson, Katon, Kroenke, (2003) which clarifies that not only are there psychosocial ties between pain and negative affect but also the biochemical ties between pain and negative affect. "Depression and pain share biological pathways and neurotransmitters, which has implications for the treatment of both concurrently" (Bair in nih.gov/pubmed/). In fact, as mentioned previously, not only is there 'overlap' in the brain between affective disorders and pain but the psychiatric "treatments for these conditions are

often the same (e.g., antidepressants and cognitive behavior therapy)" (parenthesis theirs, Karp and Reynolds 2009 p. 22). Indeed, in TFT, the algorithm protocols are the same for both illnesses (Gallo, 2005, p. 165.)

Lastly, Gallo (2005) suggests that the human interaction of the therapy itself and not just the (also important) interpersonal empathy may be important. He proposed, "perhaps the therapist's tapping serves to affect the client's energy system adding an extra therapeutic boost to the process" (Gallo, 2005, p. 130). In fact, with all the evidence presented herein, it is ironic, if not shocking, that EP therapists themselves report lower self-administered results in at least one study. "Contrary to expectations neither, Reconnective healers nor Reiki practitioners, appear to enter a more physiologically relaxed state during self-practice" (Baldwin and Schwartz, 2012, p. 299).

So far, this section of the paper has addressed six of EP's major contributions and six important ideas about how and why it works. Now a few of the within EP controversies will be briefly mentioned and then some of the controversies of meridians and chakras will be discussed. Briefly, one controversy is the use of muscle testing. Judith Swack (2002) reported, "Manual muscle testing was essential at every step of the treatment" and from Gary Craig that "muscle testing was not necessary" (www.healing-with-eft.com). Another example of controversy is with measuring. While most practitioners use SUDS for pre/post outcome measures, not all agreed. Baker, Carrington & Putilin, (2009) stated, that when discussing patient feedback, that SUDS should not be used as an outcomes measure but as a process measure. In terms of measuring the energy itself, Callahan & Callahan (1996 in Feinstein, 2009) report EP works with "subtle energies and thought fields that cannot be measured." Finally, even a "need for a definition of clinical EFT" is sought by Church (Church, 2013, p. 645). More work remains, indeed.

One technical and complex controversy involves meridians and chakras. For example, in Brief, Multi-Sensory Activation (BMSA) practitioners utilize tapping. However, Dr. Andrade's explanation for why tapping works is somewhat contentious and he repudiates chakras and meridians. First before discussing Dr. Andrade's ideas, let us review ideas of chakras and meridians. Clinton reports, "Matrix Work" . . . uses the major Chakras rather than acupuncture points to move negative energy out of and positive energy into the client (http://www.feelingfree.net). Further, matrix work "utilizes the major chakras because 4000 hours of clinical investigation suggest that they are more powerful than other acupressure points or minor Charkas" (http://www.feelingfree). Similarly according to Gallo (2005), Goodheart also found that he could revive the client's pain "by tapping on the meridian's respective sedation point" (p. 165). Meridians refers to Ching which means approximately "to pass through" and lo, "to connect" (Dale, 2009, p. 161). Dale (2009), reports that some allege, "Meridians as a tubular system that is divided into superficial and deep systems which in turn is further subdivided" (p. 176). Other similar ideas depicting interventions with chakras and meridians as crucial to healing include those of Tiller. Tillerfoundation.com reports, "acupoints lie along the 'cleavage planes between two or more muscles. They are surrounded by loose connective tissue, which in turn is surrounded by thick and dense connective tissue of the skin."

Dr. Andrade disagrees. He reports that, "all the data that we have collected suggest that there are strong non-specific functions of hsue (pinyin for "loci," incorrectly translated as 'points') meaning that we can get at least some results tapping on almost any area of the skin" (www.bmsa-int.com). In fact, he reports BMSA works due to "an effect of rapidly extinguishing conditioned responses" (www.bmsa-int.com). According to the web page, "The vast majority of practitioners of the classical tapping systems believe (this is a key word) that the incorrectly-named "meridians" and the also incorrectly-named

"points" or "acupoints" have actual existence" (www.bmsa-int.com). Further, Dr. Andrade explains his position of a misunderstanding this way on his website (www.bmsa-int.com):

> If "meridian" is a misnomer for channels or vessels, given by the French consul to China, Soulié de Morand in 1934, the name of "point" given to acupuncture loci is even less appropriate. The Mandarin denomination is hsue, which means a hollow area, not a point, which is the intersection of two lines. The Nei Ching describes 360 hsue."

Lastly, Dr. Tiller takes the whole idea even further. He suggested that patient's healing relates to debated theories of "subtle energies, rates of vibration, and the effects between the astral energy world and physical world uniting" (Tiller in Cowan, 2005, p. 49). In fact, Tiller not only recognizes chakras but describes their purpose and he wrote:

> "how both subtle and environmental energies act on the chakras as currents or waves affecting systems in the body and the functioning of the chakras. This system is viewed as a way to almost step down energies from the etheric in wave-like forms to explain the functioning of the chakra and energy system…" (Tiller in Cowan, 2005, p. 49).

Furthermore, "Goodheart developed a meridian-based pain alleviation treatment, which he refers to as the Melzak-Wall pain treatment" (Walther, 1988, in Gallo, 2005, p. 165)." Basically he had found a way to locate "meridians (which) are deficient in chi, the procedure involved tapping on the respective tonification points" (Gallo, 2005, p. 165). This theory may share some common denominators with Clinton's ideas of the five chakra states (Clinton, 2005). Although beyond the scope here, it is well worth noting EP offers other esoteric ideas regarding chakras. In a class handout, Mollon (2008, p. 252) quotes Tansley (1972) as describing the condition of the chakra to be in one of five "states of arousal." Furthermore, Kumar (2004) suggested that chakras may be linked to past lives and she suggests the second chakra is often the 'center' for that.

Some controversial issues extend beyond EP. Feinstein (2008) explains that face validity problems of EP derives from "an unfamiliar paradigm" which to non EP therapists seems strange including "meridians, charkas, and other Eastern ideas" and EP "claims both a high level of improvement in a few sessions." And interestingly, John Freedom from ACEP wrote, "the resistance to EP from the mainstream therapeutic community many have to do with cognitive dissonance; reports like these (about the efficacy, rapidity, etc) of EP simply don't fit into their paradigm; therefore, to maintain cognitive consonance, they dismiss it" (http://www.noetic.org).

Meanwhile, things are moving forward for EP as more research continues to be published. For example, a somewhat undeveloped but intriguing hypothesis about the workings of EP is found in the science of epigenetics. This may show a mechanism of action for energy psychological interventions and possibly energy medicine in general (Church, 2007). Only, future work in this area will tell. In conclusion, this article has explored basic theoretical (context, research) ideas and practical issues (why it works, major contributions, and controversies) of Energy Psychology (EP) including issues in terms of pain and related negative affect.

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Table 1 List of Research for Dual Diagnosis

Table 1. (Karp and Renolds, T.1. P. 2009)

Published Studies Documenting Relationship Between Pain and Depression in Older Adults

Authors age (years) Main Findings:

Bradbeer et al., 2003 65 People with pain had higher depression scores.

Bruce, 2002 65 Pain increased the odds of major depression odds ratio (OR) 1.27–2.62 .

Carrington Reid, 2003 70 Depression increased odds of developing chronic disabling back pain (OR 3.7–16.4).

Chou and Chi, 2005 65 Baseline pain predicted depression at follow-up.

Croft et al., 2005 65 Prevalence of depression increased with number of painful sites.

Ferrell et al., 1990 89 Pain measures correlated with inability to participate in enjoyable activities.

Finne-Soveri and Silvis, 1998 65 Depression increased the odds of daily pain (OR 1.10–3.41).

Harris et al., 2006 65 Moderate-to-severe baseline pain predicted onset of depression (OR 1.3–3.5).

Hein et al., 2003 60 Lifetime history of joint pain increased risk of late-onset major depression (OR 1.07–1.68).

Jakobsson et al., 2004 85 Depressed mood and lower quality of life more common in those who self-reported any pain.

Jongenelis et al., 2004 55 Pain increased the odds of major depression.

Karp et al., 2005 69 Pain may be associated with a more difficult to treat depression.

Lamb et al., 2000 65 Depression more common with moderate (OR 1.0–2.7) and severe pain (OR 1.2–3.6).

Magni and Frisoni, 1996 75 Depression severity increased with number of pain sites.

Mavandadi et al., 2007 60 Pain interference moderates the effects of pain severity on depression treatment.

Meyer et al., 2007 65 Depression increased the risk of disabling low back pain after 2 years and vice versa.

Parmelee et al., 1991 60 Pain intensity and extensity higher in those with major depression.

Thielke et al., 2007 60 Collaborative care intervention for depression was more successful in those with less pain.

Unutzer et al., 2004 60 Depressed older adults reported functional impairment from pain and history of chronic pain

Wang et al., 1999 65 Headache frequency, severity, and chronicity associated with higher depression severity.

Williamson and Schulz, 1995 55 Pain measure correlated with depression symptoms.

Williams and Schulz, 1992 50 Pain predicted depression after controlling other variables in regression.

Won et al., 1999 65 Daily pain for 1 week had higher odds of "impaired mood."

Table 2. Feinstein's List of Research on EP

Table 4: Seven Controlled Trials with Potentially Strong Generalizability Showing EP to Be Statistically Superior to Other Treatment Conditions

Source *peer reviewed	**Condition**	**Treatment, N**	**Controls, N**	**Measures**	**Diff.** *p*<
Schoninger, 2004	Public speaking anxiety	1 TFT Session, N=24	Wait-list, N=24	SUD, Speaker Anxiety Scale, Trait/State Anxiety Scale	.001 .001 .001
Sezgin & Özcan, 2004	Test-taking anxiety	Training in EFT, N=16	Relaxation Training, N=16	Standardized test- anxiety inventory	.05
Elder, et al., 2007*	Weight loss maintenance	10 hours group TAT sessions over 12 weeks, N=27	10 hours group qigong sessions over 12 weeks, N=22	Maintenance of weight loss after 10 group sessions and then 12 weeks later	.006 .000
Korber, et al., 2002*	Anxiety, pain, and elevated heart rate following injury	Paramedic-applied acupressure before transport to hospital, N=20	Paramedic-applied sham-acupuncture N=20, No treatment, N=20	Pulse rate; Visual analog scale for anxiety pain	.001 .001 .001
Wells, et al., 2003*	Specific Phobia (partial replication of Wells)	30-min EFT Session, N=18	30-min Diaphragmatic Breathing Session, N=17	SUD, Standardized Fear Survey, Behavioral Approach Task	.005 .005 .02
Baker & Siegel, 2005	Specific Phobia (partial replication of Wells)	45-min EFT Session, N=11	45-min Supportive Counseling, N=10	SUD, Fear Questionnaire 1, 2, Behavior Approach Task	.001 .02 .001 .03
Salas, 2001	Specific Phobia (partial replication of Wells)	1 Session EFT, 1 Diaphragmatic Breathing, N=22 (half in each order)	Subjects were own controls	SUD, Beck Anxiety Inventory, Behavioral Approach Task	.01 to .001

Note: EFT = Emotional Freedom Techniques; RCT = Randomized Controlled Trial; SUD = Subjective Units of Distress; TAT = Tapas Acupressure Technique; TFT = Thought Field Therapy.