How Energy Psychology Changes Deep Emotional Learnings

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The stimulation of acupuncture points (acupoints) by tapping on them—used in conjunction with more conventional psychological interventions—has been shown to be effective in the treatment of a spectrum of psychological disorders (Benor, 2014). Known as "energy psychology" (Gallo, 1998), a variety of protocols have been developed, with Emotional Freedom Techniques (EFT; Craig, 2010) and Thought Field Therapy (TFT; Callahan & Callahan, 1996) being the best known and most widely practiced. Outcome investigations suggest that including the somatic elements of the approach can resolve a range of clinical symptoms with greater speed, power, and precision than psychological interventions alone (see reviews in Church, 2013; Church, Feinstein, Palmer-Hoffman, Stein, & Tranguch, 2014; Feinstein, 2012).

The Treatment Sequence

The early phases of energy psychology treatments generally parallel other therapeutic approaches in that the focus is on establishing rapport, discussing the clinical framework, and identifying the presenting problem(s). The clinician remains particularly alert for emotional, cognitive, and behavioral responses implicated in each presenting problem and the cues, contexts, or memories that trigger them.

Once a salient trigger–response pair has been identified for the initial round of tapping, typically in collaboration with the client, the amount of distress the client experiences when bringing that trigger–response pair to mind is given a 0 to 10 rating on a Subjective Units of Distress (SUD) scale (after Wolpe, 1958). An "acceptance statement" is then formulated (e.g., "Even though I have all this anger toward my father, I deeply love and accept myself"). It is repeated several times while tapping or massaging certain acupoints or other prescribed energy spots on the surface of the skin that are believed to facilitate a somatic implanting of the affirmation.

The first tapping sequence involves between 4 and 14 predetermined acupoints. The tapping is usually self-administered by the client, who firmly taps each point with the forefinger and middle finger while stating a "reminder phrase" that keeps the emotional response active. (The therapist may also shift the wording during this process to target different aspects of the problem.) After going through the tapping points, an "integration sequence" is often used which involves a variety of physical procedures, all believed to integrate left- and right-hemisphere activity while helping process the emotions activated by the treatment. This is followed by another tapping sequence using the same points as previously. The steps from the initial acceptance statement to this second tapping sequence are sometimes referred to as a "round".

After each round, another SUD rating is taken, often followed by discussion. The therapist may pose questions such as "How do you know it is still at an 8?" or "What sensations are you aware of when you bring the situation to mind?" The therapist also stays alert for internal objections to overcoming the distress (called "psychological reversals") or for pertinent aspects of the problem that have not been addressed. Any of this may shift the focus of what is targeted for mental activation during the next round. The process is repeated until the SUD rating is down to 0 or near 0. At that point, another dimension of the presenting problem may be addressed.

First-Take Skepticism

On first witnessing a demonstration of these strange-looking procedures some 15 years ago, I wondered what tapping on the skin could possibly have to do with psychotherapy and why anyone would be claiming that it is more effective than established therapies which enjoy strong empirical

support. At the time, no peer-reviewed efficacy research had been published, only passionate claims from a small number of fringe therapists who were enthusiastically promulgating the method. Watching a demonstration of the new "tapping therapy", I was surprised to be catapulted into some serious cognitive dissonance.

I had been invited as a guest to a monthly meeting of local psychologists while visiting their city. The program that evening featured a member of the group who had recently introduced energy psychology into his practice. He was going to do a demonstration of the method with a woman being treated for claustrophobia by another of the group's members. Having done research on "new psychotherapies" while at the Johns Hopkins Department of Psychiatry early in my career, I was keenly attuned to the influences on therapeutic outcomes exerted by factors such as placebo, allegiance, charisma, the contagion of a therapist's belief in a method, and the suggestive power that any clinical intervention may wield.

My skepticism only mounted as I watched the treatment unfold. While what occurred during the first few minutes was familiar and comfortable for me—taking a brief history of the problem (which had not responded to treatments from several therapists) and having the client imagine being in an elevator and giving it a rating of 10 on the 0–10 SUD scale—the next part seemed laughable. The client followed the therapist's lead in tapping on about a dozen points on the skin while saying out loud, "fear of elevators". This was followed by a brief "integration sequence" that included a set of odd physical procedures and then another round of tapping. When the client next rated being in an elevator, her SUD had diminished, from a 10 to a 7. She said her heart wasn't pounding as fast. I was surprised to see any decrease in her sense of distress. I was at the time using systematic desensitization for such cases, while this new procedure did not utilize any relaxation methods and required only two or three minutes from the first rating to the second. Perhaps the woman had developed some affection or loyalty to the therapist and didn't want to embarrass him in front of his colleagues.

Another round of the procedure brought the SUD down to a 5. After another round, however, it was back up to a 7. I was thinking, "See, just superficial fluctuations caused by the set and setting. I knew it wouldn't work!" When the therapist inquired, the woman reported that a memory had come to her of being about eight and playing with her brother and some of his friends. They had created a fort out of a cardboard appliance box. When she was in it, the boys closed the box and pushed the opening end against a wall so she was trapped in the box. They then left her there amidst laughter and jeering. She didn't know how long it was until she was found and freed, but in her mind it was a very long time, as she had been screaming till exhausted. She had not recalled this incident for years, and she rated the memory as a 10.

I thought, "Okay, so something was accomplished! A formative event has been identified that some good psychodynamic therapy will be able to resolve over a series of sessions. However strange the method, it has led to an important discovery that will give the treating therapist a new direction. It has been a useful case consultation." But that's not where it ended. The therapist doing the demonstration started having the woman tap using phrases related to the earlier experience. Within 15 minutes, she was able to recall the incident with no subjective sense of distress (SUD at 0). They then returned to elevators and quickly had that down to 0 as well. I looked on with my skepticism fighting what my eyes and ears were registering.

One of the group members suggested that it would be easy to test this, and the woman agreed to step into a hallway coat closet and shut the door. The therapist was careful to make it clear to her that she was to open the door at any point she felt even slightly uncomfortable. The door closed. We waited. And waited. And waited. After about three long minutes, the therapist knocked and asked if she was okay. She opened the door and triumphantly announced that for the first time since childhood, she was comfortable in a small enclosed space. Meanwhile, I was thinking, "Okay, I'm onto them now! This is a social psychology experiment. We are about to be informed that we have been subjects in a study of how gullible therapists can be!" That announcement never came.

Searching for an Explanation

That demonstration was persuasive enough to cause me to look further into energy psychology and then to go through a certification program in the method. I was finding that the protocol gave a tremendous boost to my clinical outcomes. The physical procedures did not resemble anything I had learned in my clinical training, but when I experimented, I found that without them the psychological procedures were not nearly as effective. As research began to accumulate that corroborated what I was observing with my own clients, and what was being reported by colleagues who were using the method, the question that became most prominent in my mind was, "Okay, if it works, how does it work?"

The first compelling clue came when I learned about an ongoing research program at Harvard Medical School. The investigators were using imaging equipment to document the physiological effects of

tion of theta waves after claustrophobia treatments (Lambrou, Pratt, & Chevalier, 2003), and decreased right frontal cortex arousal in treating trauma following motor vehicle accidents (Swingle, Pulos, & Swingle, 2004), all corroborated by improvements on pre-/post-treatment psychological measures. Together, these laboratory findings suggest that the stimulation of specific acupuncture points, with or without needles, can bring about precise, intended outcomes—such as the deactivation of an amygdala-based fear response to a specific stimulus.

Bingo! Or so it seemed. The primary mechanism in energy psychology appeared to be that after using a reminder phrase that brings about limbic-paralimbic-neocortical arousal, tapping on acupoints sends signals to the amygdala and other brain structures that immediately reduce that arousal. This would provide a plausible explanation for the rapid effects that have been widely reported by clinicians using the method, as well as an explanation for why the interventions can be targeted to bring about precise, desired outcomes. The reminder phrase selected determines the trigger–response pairing that will then be neutralized by the signals the acupoint stimulation sends to the limbic system.

Acupuncture is able to produce "extensive deactivation of the limbic-paralimbic-neocortical system"

simulating specific acupuncture points. For instance, the needling of a particular acupoint on the hand (Large Intestine 4) produced prominent decreases of fMRI-registered activation in the amygdala, hippocampus, and other brain areas associated with fear and pain (Hui et al., 2000). Subsequent studies by the same team led to the conclusion that "functional MRI and PET studies on acupuncture at commonly used acupuncture points have demonstrated significant modulatory effects on the limbic system, paralimbic, and subcortical gray structures" (Hui et al., 2005, p. 496). Further investigation provided "additional evidence in support of previous reports" that acupuncture is able to produce "extensive deactivation of the limbic-paralimbic-neocortical system" (Fang et al., 2009).

Meanwhile, a series of reports using electroencephalogram (EEG) analysis to explore neurological effects of acupoint *tapping* (as contrasted with the traditional use of needles) showed normalized brainwave patterns upon activation of a traumatic memory that had disrupted such patterns prior to treatment (Diepold & Goldstein, 2009), normaliza-

However, while I found this explanation to have appeal, I quickly realized it was incomplete. It did not, in fact, account for the most critical piece of the puzzle. How do a few rounds of tapping while mentally activating a problematic response *permanently* change that response? Even if the tapping does send deactivating signals to the brain structures that maintain the unwanted response, resulting in temporary relief, wouldn't tapping be needed *every time* the trigger–response pairing was activated, in order to prevent the response? Yet follow-up investigations have shown the clinical benefits of energy psychology protocols persist with no further treatment (Church, 2013; Feinstein, 2012).

Therapeutic Reconsolidation: The Missing Piece of the Puzzle

Enter the findings about memory reconsolidation that began to emerge in the late 1990s from labs around the world. Hundreds of studies have shown that "a consolidated memory can return . . . to a labile, sensitive state—in which it can be modified,

strengthened, changed or even erased!" (Nader, 2003, p. 65). Another, more powerful mechanism than *extinction* was being proposed to explain how the brain updates itself on the basis of new experience. The prevailing belief among neuroscientists had been that once a new learning is consolidated into long-term memory, it is permanently installed. It could be modified, or even eclipsed by subsequent experiences, as in extinction training, but it nonetheless remained and could be reactivated. Reconsolidation researchers were showing that if specific conditions were met after reactivation of an existing learning, that learning became labile, that is, capable of being altered or even completely erased and replaced with a new learning that integrated a current experience into the context of the original learning. The far-reaching implications of this discovery are delineated for clinicians in Ecker, Ticic, and Hulley's (2012) *Unlocking the Emotional Brain: Eliminating Symptoms at their Roots Using Memory Reconsolidation.*

The findings on memory reconsolidation show that despite the stubborn tenacity of deep emotional learnings, the brain has a mechanism for "updating existing learnings with new ones" (Ecker et al.,

revised or altogether eradicated when a set of precise conditions has been met. Called the "transformation sequence" (p. 41), three interrelated experiences must occur:

1. The emotional memory or learning must be vividly accessed.

2. A "juxtaposition experience" that contradicts the implicit models or conclusions drawn from the original experience must concurrently be activated.

3. The juxtaposition pairing must be repeated several times.

Studies in labs and clinical settings, using both animal and human subjects, all point to this simple, commonsense sequence of steps as the way new experiences are incorporated into established models of how the world works and one's place in it. These steps seem to be nature's key for chemically unlocking the synapses that maintain deep learnings established in the past during highly charged emotional experiences, and for allowing them to be reconsolidated in a new way based on more recent experiences.

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2012, p. 26). While core beliefs and mental models formed in the presence of intense emotion during childhood or later "are locked into the brain by extraordinarily durable synapses" that typically persist for the remainder of a person's life (p. 3), neuroscience research since 2004 has demonstrated that these core beliefs and mental models can be modified or totally eradicated. By facilitating a specific sequence of experiences, targeted emotional learnings can be activated and their synapses unlocked "for prompt dissolution of . . . retrieved learnings at their emotional and neural roots" (p. 8).

Through this process of "depotentiating" (deactivating at the synaptic level) the neural pathways maintaining implicit learnings that are at the basis of psychological problems, "major, longstanding symptoms can cease [because] their very basis no longer exists" (Ecker et al., 2012, p. 4). Whether in the lab, the consulting room, or the daily flow of life experiences, the deeply embedded learnings that "underlie and generate" (p. 14) a large proportion of the symptoms presenting in psychotherapy can be

While not all psychotherapy facilitates this transformational sequence, Ecker et al. (2012) maintain that if the therapy produced basic markers of permanent change of an acquired response, these steps must have occurred "whether or not the therapist or client was cognizant of this sequence of experiences taking place" (p. 127). They maintain, in fact, that this model is a "meta-conceptualization" (p. 129) that transcends the theories and techniques of specific schools of psychotherapy, and that it can be applied to the implicit learnings that are at the foundation of a wide range of psychological symptoms, whether "formed in attachment, existential, social, traumatic, or other experiences" (p. 126).

How Energy Psychology Protocols Utilize Reconsolidation

In introducing the earliest acupoint tapping protocols, Callahan (1985) formulated a set of procedures that were, by intuition or by accident, remarkably attuned to the findings on memory reconsolidation that would emerge two decades later. Each of the steps in the transformation sequence identified by Ecker et al. (2012) occurs by following the core procedures of an energy psychology protocol. Even without the therapist or the client thinking in terms such as "juxtaposition experiences", "disconfirming knowledge", or "reconsolidation", the steps of the transformation sequence nonetheless occur.

appreciated, a process that Ecker et al. (2012) use to normalize and humanize the client's symptoms and treatment. If, as is often the case, it proves necessary to address the original formative experiences to completely resolve the presenting problem, and the relevant memories do not arise spontaneously, techniques for bridging to earlier memories, such as following a current feeling or bodily sensation back to one of the first times it was experienced, are frequently used.

Step 2: A "juxtaposition experience" that contradicts the implicit models or conclusions drawn from the original experience must concurrently be activated. The second step in the sequence—

> ### The memory or trigger created a strong expectation that an unpleasant emotional reaction would be evoked, but the expected response did not occur, because acupoint stimulation had temporarily deactivated the limbic response.

Step 1: The emotional memory or learning must be vividly accessed. In a typical energy psychology treatment, the initial rounds of acupoint tapping most often involve activating the symptom or presenting problem using images, evocative phrases, or a felt sense of the problem. That scenario inevitably contains the implicit learnings underlying the symptoms. For instance, when the woman discussed above brought to mind being in a closed space by means of imagery and the reminder phrase "fear of elevators", the implicit belief that closed spaces are dangerous and to be avoided was activated. The formative experiences that established such a learning do not necessarily need to be accessed, but they frequently emerge. When the tapping has removed some of the emotional edge of the current problem, childhood memories involved with the presenting problem tend to spontaneously enter the client's awareness. When this happens, they generally become an area of focus, as occurred when the memory of being trapped in the appliance box came into the woman's mind. This allows the adaptive historical function of the symptom to be recognized and

generating an experience that disconfirms the earlier learning—is the most complex stage for most reconsolidation-oriented therapies, but it is where energy psychology protocols are shown to greatest advantage. Because stimulating selected acupoints rapidly reduces limbic arousal (Fang et al., 2009; Hui et al., 2000, 2005), the emotional landscape changes *during* the exposure. A traumatic memory or trigger that produced a physiological threat response is vividly imagined, but the disturbing physiological response is no longer present. The brain is already experiencing a mismatch from learned expectations. The memory or trigger created a strong expectation that an unpleasant emotional reaction would be evoked, but the expected response did not occur, because acupoint stimulation had temporarily deactivated the limbic response. As the woman imagined being in an elevator without feeling the expected fear and racing heart, a mismatch occurred between her experience and her expectation. This juxtaposition of holding the troubling scene simultaneous with no physiological arousal is the mismatch that unlocks the neural pathway maintaining the old learning so it can be transformed by the new experi-

ences in the next step. The mismatch or "disconfirming experience" in energy psychology treatments is generated simply by tapping on the skin—almost too easy to believe. The required mismatch is effected by bringing the trigger to mind while preventing the expected threat response from occurring via the deactivating signals the acupoint stimulation sends to the limbic system. Other therapies usually have to work much harder to create suitable mismatch experiences.

Step 3: The juxtaposition pairing must be repeated. Energy psychology protocols involve substantial repetition. Not only are as many rounds as necessary carried out to bring the SUD rating down to 0 or near 0 (in some cases having some subjective distress is considered adaptive), but every aspect of the problem that can be identified as evoking subjective distress is treated. In addition, therapists learning energy psychology are taught to challenge their positive outcomes. They might ask the client to try to reproduce the fear, pain, anger, or other disturbing emotion associated with the target memory or trigger by making the imagery more vivid or simply willing the earlier emotion to return. They might test the results by having the client imagine contexts that are even more severe than the original tapping scene and more likely to trigger distress. Back-home or other in vivo tests are also encouraged and discussed.

a) identifying the target symptom, b) identifying the implicit learnings that maintain the symptom, and c) identifying knowledge within the client's experiences and beliefs that contradicts the learnings that maintain the symptom. Then, to *verify* that the transformation sequence has been successful, Ecker et al. turn to the same markers that neuroscientists use in laboratory studies to determine whether an emotional learning has been permanently eradicated via reconsolidation: the change was abrupt rather than incremental, the symptom-generating emotional reactions that had been triggered by specific cues and contexts are absent, and the change persists "without effort or counteractive measures" (p. 127). In what follows I will explore how these additional phases of treatment played into a case study.

Energy Psychology and Reconsolidation: A Case Study

In selecting a case to review in terms of the therapeutic reconsolidation model, I simply chose my most recent published case (Eden & Feinstein, 2014, pp. 221–224). As part of a book for the general public, it was not written to illustrate the reconsolidation process, and I thought it would be an interesting experiment to see how readily it fitted with the Ecker et al. (2012) model. I have structured the commentary so you can judge the results of this experiment for yourself. The descriptions of the case and

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The Preliminary and Verification Phase

For clinicians to purposefully bring about what is termed "the therapeutic reconsolidation process" (p. 126), Ecker et al. (2012) describe a set of preliminary steps that are generally necessary to set up the transformation sequence outlined above and also a verification process that follows the transformation sequence. The three *preliminary* steps include

the treatment are taken from the published version, edited and abridged only slightly to fit this context. The comments bridging it to the conditions necessary for therapeutic reconsolidation are new and are in italics.

Background. Jeremy was 36 when he married Melissa. He was eager to help raise her sons, aged 7 and 9. He had gotten to know them quite well dur-

ing the year prior to the marriage, had taken them to baseball games, zoos, parks, and other local attractions, and had participated in their hobbies. The boys liked their stepdad and the attention he was giving them, and the new family was blossoming within an atmosphere of affection and promise. Melissa's ex-husband, Steve, the boys' biological father, had not been particularly eager to spend time with his sons during the marriage, but he also loved them. He had moved to another town several hours away after the divorce but had been reliable in taking the boys for the afternoon every other Sunday.

During his courtship with Melissa, Jeremy had never met Steve. But now that Jeremy had moved in with the family, the twice-monthly visits became a fixture in his life. He was civil enough toward his new wife's ex, but he avoided having much contact with him when the boys were being picked up or dropped off. During the first Christmas vacation after the marriage, Steve arranged to take the boys for a week, and the three of them flew to Orlando for a Disney marathon. The boys were so excited about it that they seemed to talk of little else for the week prior to and for the week following the trip. When Steve came for the next Sunday visitation, Jeremy could hardly look at him. He began to criticize Steve's parenting style to Melissa, point out his culpability in the divorce, and generally paint an ugly picture of the man who had fathered her children. At first Melissa acknowledged the truth in some of the observations, but over time Jeremy became increasingly vehement in his criticisms. This grew into a loaded theme in their interactions on the weekends that Steve would be arriving, and Jeremy began questioning the boys about their visits with their father, as if looking for more fodder for his rants. He was eventually unable to hide from the boys his disdain toward their father.

Jeremy's jealousy toward Steve continued to escalate, and the acrimony was seeping into other areas of the family. As Steve's visits approached, tension would descend onto the household. The boys were confused. Melissa began to judge Jeremy harshly. She had more than once called him a "spoiled brat". This was the state of things when they scheduled a couple counseling session with me.

Preliminary phase. Jeremy knew at some level that his reactions were not rational, but this knowledge was no match for the strength of his emotions. When Jeremy was triggered, Steve was an evil man sabotaging all of Jeremy's fine efforts with the boys and the family, and there was no other reality to consider.

After hearing both of their renditions of the problem, I spoke to the part of Jeremy that knew his reactions to Steve were extreme. I explained that when intense emotions are triggered, they are very real, whether rational or irrational. I suggested tapping to take the edge off the intensity of Jeremy's responses to Steve. Neither Jeremy nor Melissa had any experience with energy psychology, but the couple who referred them had worked with me and described the method, so they were game for anything that could help, however strange it might seem. While Jeremy was not open to considering that his assessment of Steve might be wrong, he was interested in feeling less consumed by his reactions. *We had accomplished only the first of the three preliminary steps—"identifying the target symptom"—before the first round of tapping. Jeremy knew his reactions to Steve were extreme and that was what he wished to change. As you will see, the next preliminary step, "identifying the implicit learnings that maintain the symptom", occurs during the tapping protocol.*

First round of tapping. The scene that Jeremy chose for the first SUD rating was from the previous Sunday, watching as Steve's car pulled into the driveway. He gave it a 10. *So we have activated the emotional reaction, but not yet completed the first step of the transformation process by identifying the emotional learning—the implicit meanings or models—that are driving the reaction.*

After four rounds of tapping, the SUD had gone down to a 7, but even after further tapping it seemed to be stuck there. I asked, "How do you know it is a 7?" Jeremy said that he felt pressure in his chest and a tightness in his throat. I asked him to explore the feelings in his throat. He said it was almost as if he were trying to hold back tears. I asked if he could remember one of the first times he had that feeling. He immediately recalled being 10 when his parents brought a foster boy into the family. It was to be a temporary arrangement until a permanent placement could be found, a favor for a relative of the boy, but it changed everything for Jeremy.

As an only child, Jeremy had enjoyed his parents' full attention and affection. Suddenly, that was his-

tory. The foster boy had many problems, both of Jeremy's parents held full-time jobs, and the limited time and resources they had available shifted from Jeremy to the new boy. Jeremy, at 10, did not have words or concepts that could help him come to grips with the loss. He felt emotionally abandoned by both of his parents, could not fathom why they had brought this troublesome person into their home, and he hated the foster boy. He began starting fights and creating acrimony wherever he could. This strategy seemed to eventually work. After about a year, the agency found a permanent placement for the boy and Jeremy never saw him again. All of this had faded from Jeremy's awareness. He hadn't thought about it for years, and no other circumstance in his adult life had triggered his unprocessed feelings around that phase of his childhood. He had never thought to mention it to Melissa, but the parallels between the foster boy and the situation with Steve became immediately obvious to all three of us.

This insight and its subsequent exploration accomplished the second preliminary step, "identifying the implicit learnings that maintain the symptom", as well as completing the first step of the transformation process, "vividly accessing the emotional learning". Jeremy now recognized that he was projecting onto Steve the model he had formed during his experience with the foster boy, admitting that he was afraid Steve was going to render him peripheral and alone, just as the foster boy had done. Notice that we are not going in the exact order of completing the preliminaries before starting the transformation process, nor do Ecker et al. (2012) imply that the steps are fixed. In fact, as you move into the transformation phase, additional information that corresponds with the preliminary topics for exploration organically emerges and may subsequently be utilized.

Neutralizing salient aspects of the problem. We tapped on every aspect of the memory we could identify, staying with each until subjective distress was down to a 0: Jeremy's loss of his parents' attention; his many times having held back tears when he felt lonely and abandoned; his confusion and puzzlement about what he had done wrong to deserve having all the attention withdrawn from him; the invasion into his family; his hatred for the new boy; the fights they had; his being punished for starting them and feeling like a bad boy after 10 years of being a good boy; and even his confusion when the new boy suddenly disappeared.

Fortunately, each round of tapping takes only a couple of minutes, so all of this was accomplished within that first session (I generally schedule two hours for initial sessions with couples). Jeremy was by then able to talk lucidly and calmly about the foster boy and the boy's invasion into his young life. *We now see Jeremy vividly having an initial set of juxtaposition experiences, the second step of the transformation process. His memories about the foster boy are no longer paired with feelings of anger, hate, jealousy, and abandonment. This was accomplished simply by evoking the memories and neutralizing the emotional responses using the acupoint tapping.*

Completing the transformation sequence. Now Jeremy could reflect on how Steve's visits with the boys were bringing up feelings that could be traced back to his experiences with the foster boy. *Finally, we get to the third preliminary, "identifying knowledge within the client's experiences and beliefs that contradicts the learnings that maintain the symptom". Jeremy was recognizing that his sense of Steve purposefully trying to destroy Jeremy's family seemed to have more to do with this earlier scenario than with the current one. He was now able to simultaneously hold two possibilities: the still somewhat emotionally charged framing from the old learning that "Steve is trying to destroy my family and upset my place in it", and the emotionally benign framing from the new learning that "Steve is just visiting with his boys like any father gets to do, and even though it sure reminds me of what I went through at 10, he really isn't a threat to my relationship with the boys".*

Focusing again on watching Steve's car pulling into the driveway, Jeremy gave it an SUD rating of three. A couple more rounds of tapping and it was down to a 0. *We have by now created juxtaposition experiences (the second step of the transformation process) enough times and in enough contexts (first with the foster boy and then with Steve) to accomplish the third step, which is the repetition of the juxtaposition experiences. The conditions have been met for Jeremy to permanently revise, through the therapeutic reconsolidation process, the deep emotional learnings from his childhood that were driving his reactions to Steve.*

Addressing fallout. We then briefly focused on Melissa's horror and sense of betrayal about Jeremy's shift over the recent months from an appar-

ently ideal stepfather to an angry, jealous, irrational force in her home. Witnessing what we had gone through with Jeremy had already put all of this into a welcome new light, and by the end of the session, Melissa was able to review the strange course of their young marriage with no emotional charge.

Follow-up. On a follow-up session two weeks later, the issue had vanished. Jeremy was not triggered by Steve's next visit, the strong relationship Jeremy had established with the boys and with Melissa was back on track, and I had lost customers who could easily have spent a year or two in counseling. Such are the risks a therapist takes when diving right into the therapeutic reconsolidation process. *The verification phase of the treatment was accomplished in*

Another pertinent observation is that the "mismatch" component—the visceral experience that contradicts the client's existing emotional knowledge and becomes the basis for the new learning—"must feel decisively *real* to the person based on his or her own living experience . . . it must be experiential learning as distinct from conceptual, intellectual learning, though it may be accompanied by the latter" (p. 27). One of the most satisfying and frequently repeated experiences for energy psychology practitioners is watching the astonished expression on a person's face when bringing to mind a memory or trigger, or entering an in vivo situation, that 15 minutes earlier was met with the physiological components of terror but is now devoid of any emotional charge whatsoever.

The change was abrupt rather than incremental, the symptom-generating emotional reactions that had been triggered by specific cues and contexts were absent, and the change persisted without effort or counteractive measures.

that the three markers of an emotional learning having been permanently eradicated were all present: the change was abrupt rather than incremental, the symptom-generating emotional reactions that had been triggered by specific cues and contexts were absent, and the change persisted without effort or counteractive measures.

Discussion

The observations of Ecker et al. (2012) regarding therapeutic change, based on an understanding of the reconsolidation of emotional learnings, are consistent with the clinical reports emerging from energy psychology. One of the most controversial yet significant of these is that "transformational change through the erasure sequence does not rely on extensive repetition over time to effect change" (p. 32). The rapid outcomes seen in energy psychology treatments are consistent with Ecker et al.'s observations about "the swiftness with which deep, decisive, lasting change occurs through the therapeutic reconsolidation process" (p. 32). This, of course, "challenges traditional notions of the time required for major therapeutic effects to come about" (p. 32).

Of particular interest with reconsolidation-informed therapies is the way that when an old emotional learning is erased, "erasure is limited to precisely the reactivated target learning, without impairing other closely linked emotional learnings that have not been directly reactivated" (Ecker et al., 2012, p. 25). Consistent with reports from energy psychology practitioners, after the learned fear response has been eliminated, "subjects still remembered the experiences in which they had acquired the conditioned fear response, as well as the fact of having had the fear, but the fear was not re-evoked by remembering those experiences" (p. 25). Ecker et al.'s (2012) observation is also clinically instructive. Energy psychology protocols treat every aspect of a problem that can be identified. It is not assumed that closely linked emotional learnings have been neutralized until they have each been addressed. For instance, a psychological aspect of the fear of elevators experienced by the woman from my earlier example was her childhood experience of being trapped in the appliance box. Both the current fear and the formative memory needed to be treated before it was likely that her phobia could be fully eliminated.

One final observation from Ecker et al. (2012)—that the treatment leads to an "increased sense of unified self and wholeness" (p. 33)—is also consistent with the outcomes reported by energy psychology practitioners. Not only are symptoms overcome, but when outdated emotional learnings are submitted to the therapeutic reconsolidation process, and old limiting beliefs and mental models transformed, new connections with neural networks that support optimal functioning are formed. Implicit memories and learnings enter the neocortex-mediated explicit memory system and integrate with neural pathways that support more adaptive coping strategies and an enhanced sense of integration. With little prompting, clients talk about themselves and their situation in more self-affirming ways. Their view of their world and their place in it becomes more complex yet more coherent and empowering.

Energy psychology protocols thus explicitly and organically fulfill the steps necessary for the therapeutic reconsolidation process. The tapping in itself does not erase or transform the embedded learning. But it does temporarily deactivate the limbic response to the memory, cue, or context that was evoking the target emotion and related learning. When the circumstances that triggered the emotion are experienced without the expected emotion occurring, the contradictory experience that is necessary for juxtaposition and therapeutic reconsolidation is unwittingly but fortuitously created. The outdated learning or model is then permanently eliminated or updated through the reconsolidation process. The client's felt sense is that a memory, cue, or context that had evoked a strong and unwanted emotional or behavioral reaction no longer triggers that reaction. The change is brought about rapidly, with precision, and it is lasting.

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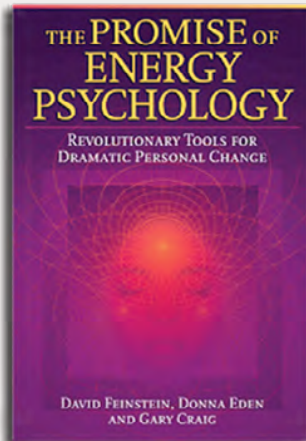
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