Trauma-Based Energy Psychology Treatment Is Associated with Client Rehabilitation at an Addiction Clinic

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Abstract

Energy Psychology (EP) comprises a set of innovative and powerful techniques that can be used to enhance treatment progress and outcomes for addiction and co-occurring disorders, particularly posttraumatic stress disorder (PTSD). This article identifies the limitations of the current addiction treatment paradigm and presents a variety of ways in which one dual diagnosis treatment program for women addresses these limitations with the EP approach. Research on EP and its mechanism of action is presented, along with specific examples of how the tools are used at the treatment facility, case studies, client and therapist feedback, treatment guidelines, and outcome data. Data for 123 clients in the program collected over a 3.5-year period include reductions in mental health symptomology during treatment as follows: depression scores from 79% at intake to 16% at last survey, $p < .001$; anxiety scores from 73% to 8%, $p < .001$; trauma symptoms from 76% to 30%, $p < .001$; suicidality from 53% to 11%, $p < .001$; binge eating from 33% to 11%, $p = .01$; and compensatory eating disorder behaviors from 41% to 11%, $p = .074$. The evidence presented indicates that EP can be a very empowering and effective adjunct to treatment for co-occurring disorders, particularly for emotional self-regulation, cognitive restructuring, and trauma processing. The data and clinical results from Avery Lane are consistent with those derived from meta-analyses, clinical trials, and experiences at other treatment centers. This body of literature demonstrates that EP is a powerful, evidence-based approach that sets the standard for effective addiction treatment.

Keywords: addiction, dual diagnosis, trauma, PTSD, depression, anxiety, Energy Psychology, Emotional Freedom Techniques, EFT

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Disclosure: The author conducts trainings and provides clinical services with the approaches examined in this paper.

Substance use and mental health disorders continue to be a largely underdiagnosed and undertreated health issue in the United States. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2020), in 2019, 20.6% (51.5 million) of all adults aged 18 and older in the U.S. were living with a mental illness. Of those, only about 44.8% (23 million) received mental health services in the previous year.

Furthermore, the National Institute on Drug Abuse (NIDA, 2020) reports that multiple national population surveys have found that about half of those who experience a mental illness during their lifetime will also experience a substance use disorder and vice versa (Santucci, 2012). This is referred to as dual diagnosis, or co-occurring disorders.

The statistics for those with co-occurring mental health and substance use disorders are discouraging. According to one study, of the 20.3 million people in the United States with substance use disorders, 37.9% also had mental disorders, and of the 41.1 million people with mental health disorders, 18.2% also had substance use disorders. For those people who needed treatment, 52.5%

received neither substance use treatment nor mental health treatment, 34.5% received mental health treatment only, 3.9% received substance use treatment only, and only 9.1% received both substance use and mental health treatment (Han et al., 2017).

Research indicates that having co-occurring disorders not only impacts treatment accessibility, but also substance abuse treatment outcomes; clients with comorbid disorders demonstrate poorer treatment adherence (DeMarce et al., 2008) and higher rates of treatment dropout (Kelly & Daley, 2013; Torrens et al., 2012) than those without mental illness.

It is also important to note the impact of trauma in the course and outcome of dual diagnosis treatment. Many environmental influences are associated with an increased risk for both substance use disorders and mental illness including chronic stress, trauma, and adverse childhood experiences (NIDA, 2020). SAMHSA (2020) reports that of those who sought mental health treatment in 2019, 44.7% have experienced trauma and 41.9% meet the criteria for a diagnosis of posttraumatic stress disorder (PTSD). Those individuals who have experienced trauma are at much higher risk for drug use and substance use disorders, with poorer treatment outcomes (Berenz & Coffey, 2012).

Current Treatment Paradigm

The efficacy of traditional standards of care for addiction treatment has been disappointing. It has not proven to address adequately the complex needs of people with co-occurring substance use and mental health disorders. According to NIDA (2020), there is a need for comprehensive and integrated therapies to address comorbid disorders, and integrated treatments for co-occurring disorders have been found to be consistently superior compared with separate treatments for each diagnosis (DeMarce et al., 2008; Kelly & Daley, 2013; Torrens et al., 2012). Yet research indicates that only about 18% of substance use disorder treatment programs and 9% of mental health treatment programs in the U.S. actually have the capacity to serve this population in an integrated way (McGovern et al., 2014).

Traditional substance abuse treatment focuses primarily on the environmental causes of addiction and utilizes psychosocial interventions such as psychoeducation and peer support (e.g., 12-Step programs) to treat it. Mental health issues are often overlooked as there has been a longstanding bias against psychotropic medication, and many programs do not employ licensed mental health professionals who can provide psychotherapy or psychiatrists and nurses who can prescribe, dispense, and monitor medications (McGovern et al., 2014). Only more recently with the growing opioid epidemic and government mandates are more treatment programs incorporating biologically based approaches such as medication-assisted therapy (MAT).

This may in part explain why success rates for long-term sustained sobriety have been notoriously low in this treatment paradigm. In a meta-analysis of alcoholism treatment outcome studies, average short-term abstinence rates were only 43% for treated individuals (Monahan & Finney, 1996). Post-discharge relapse and eventual readmission appear to be the norm, and the risk of relapse does not appear to abate until four to five years of abstinence (Dawson, 1996; De Soto et al., 1989; Vaillant, 1996). Retrospective and prospective treatment studies report that most clients undergo three to four episodes of care before reaching a stable state of abstinence (Anglin et al., 1997; Hser et al., 1997). Long-term abstinence rates at 10 years posttreatment increase to 57%, but so does the risk of mortality, with alcoholic participants being 9.5 times as likely to die as matched community controls over the follow-up period (Finney & Moos, 1991).

Another concern with the current treatment paradigm is the undertreatment of trauma and PTSD. The prevalence of PTSD is 1.4 to 5 times higher among individuals with co-occurring substance use disorders than those without (Cottler et al., 1992). Women are particularly impacted by trauma, with rates of physical or sexual abuse among treatment-seeking women with substance abuse ranging from 55% to 99%, and many of these women manifest trauma-related symptoms consistent with a diagnosis of PTSD (Najavits et al., 1997).

Trauma is often not treated in traditional substance abuse programs. While it may be identified as an underlying cause of addiction, the existing mindset has been not to process trauma in early recovery, but rather to wait until clients have at least six months to one year of sobriety. The challenge is that these clients are often unable to sustain sobriety for this long due to recurrent symptoms of trauma and PTSD such as flashbacks,

hypervigilance, heightened anxiety, and a constant state of nervous system hyperarousal. People with PTSD often use substances in an attempt to quell their anxiety and to avoid dealing with trauma and its consequences (Boden et al., 2014).

Although when they are offered, the "standard of care" therapies for PTSD—cognitive processing therapy and prolonged exposure—are proving to be more effective than supportive talk therapy alone, a meta-review by Steenkamp et al. (2015) found that while many clients received some benefit, approximately two thirds retained their PTSD diagnosis after completing treatment.

Thus it appears that these traditional treatment programs are often not addressing all of what research suggests are the underlying causes of addiction and mental disorders, nor giving people adequate coping skills for managing and processing mental health symptoms and trauma. Energy Psychology (EP) offers an innovative and comprehensive approach that may address these limitations.

Energy Psychology

What is Energy Psychology? The professional organization for EP, the Association of Comprehensive Energy Psychology (ACEP, n.d.), provides the following explanation:

> Energy psychology (EP) comprises a family of methods designed to strategically and methodically intervene with human energy fields in elevating physical, mental, emotional and spiritual wellbeing. These approaches are used by practitioners of psychotherapy, counseling, coaching, energy healing, and health optimization.
>
> EP methods combine cognitive interventions (including focused awareness and imaginal exposure to traumatic memories) with stimulation of the human bio-energy systems such as meridians, chakras and the biofield. Activation of the bio-energy system during the intervention is thought to increase the speed and/or thoroughness of the work.
>
> Practitioners view issues as systemic, interactive bio-energetic patterns. This involves constant complex communication among neurobiological processes, electrophysiology, consciousness, and bioenergy systems (which may include the biofield, chakras, and meridians). Practitioners use a variety of demonstrated and self-applied techniques to help clients shift the flow of information and energy throughout these systems.
>
> Most EP approaches are active, focused and structured. EP approaches can be: 1) used as stand-alone interventions, 2) integrated within a broader clinical treatment or program of change or health optimization.

To facilitate change, EP methods integrate concepts and techniques from related fields, including psychological science, acupuncture meridian theory, neuroscience, physics/quantum mechanics, biology, medicine, and chiropractic. Since the 1970s, these methods have been further developed, refined, and supported via clinical experience and research across multiple areas of application.

In 1980, psychologist Roger Callahan effectively applied the principles of acupressure to psychotherapy with Thought Field Therapy (TFT; Callahan, 1985). In TFT, clients focus their attention on an upsetting situation while tapping their fingertips on a series of acupuncture points (acupoints) on the body. According to traditional Chinese medicine, from which acupuncture and acupressure are derived, this stimulation of acupoints releases the energetic blocks creating the problem being addressed, restoring a balance in the energy flow in the body that allows the psychological issue to be resolved in ways not possible while internal systems are stressed (Feinstein, 2018).

Callahan effectively applied these principles in his work with clients, many of whom struggled with anxiety disorders such as phobias and PTSD. With the success of Callahan's findings, he began to offer courses in TFT and his students went on to develop their own variations on TFT, including Gary Craig's Emotional Freedom Techniques (EFT; Craig & Fowlie, 1995), Larry Nims' Be Set Free Fast (BSFF; Nims & Sotkin, 2003), and numerous others. The method most frequently researched and utilized in clinical practice currently is EFT.

EP approaches have now been incorporated into a number of existing treatment paradigms. Schulz (2009) found that licensed mental health professionals working with childhood sexual abuse frequently combined EP with more traditional trauma treatment modalities, including cognitive behavioral therapy (CBT), Eye Movement Desensitization and Reprocessing

(EMDR), and solution-focused therapy. One therapist participant in the study remarked that "energy methods are ideal for sexual abuse survivors because there is less necessity to talk about, or relive, trauma. This lessens the possibility of re-traumatization" (p. 18).

EP has also been utilized in formal treatment programs such as the Warrior Combat Stress Reset Program (Reset), an intensive outpatient behavioral health program at the Carl R. Darnall Army Medical Center in Fort Hood, Texas. Here, active-duty soldiers with PTSD were successfully treated with EP in combination with trauma-focused behavioral health techniques and complementary and alternative medicine (CAM) modalities including acupuncture, massage, Reiki, reflexology, and yoga (Libretto et al., 2015).

Typical Treatment Protocol

In a typical tapping-based EP treatment session, the client thinks about a distressing event or memory, a negative or limiting belief, a difficult emotion, or an uncomfortable physical sensation such as pain or tension, while simultaneously tapping on a prescribed set of acupoints (Feinstein, 2018). This may also (in the case of EFT) include verbal cueing that pairs the negative stressor with positive affirmations, for example, "Even though I'm feeling this anxiety, I love and accept myself."

The intensity of distress is measured throughout the treatment by rating it from 0 to 10 on a Subjective Units of Distress (SUD) scale (Wolpe, 1968). With subsequent rounds (usually one to three minutes each) of tapping through the acupoints on various aspects of the stressor, the SUD level will decrease until a sense of calmness and neutrality is reached and no subjective distress is reported regarding that aspect of the problem.

In BSFF (Nims & Sotkin, 2003), another commonly used EP technique, the subconscious mind is instructed by a cue of the client's choosing to initiate a process of clearing the negative emotional roots of an upsetting issue or problem. The cue can be a word or phrase (such as "peace," relax," or "let it go"), a visual image (e.g., a calming scene in nature), or a physical gesture (e.g., a hand on the heart). The SUD scale is used to measure the level of distress in the same way as in EFT. The client uses the cue for all thoughts, beliefs, emotions, and physical sensations that are creating distress until the SUD level decreases and a sense of calm and neutrality is achieved.

Brainspotting (BSP; Grand, 2013) derives from EMDR (Shapiro, 1995), a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories. BSP works by using specific eye positions to access, process, and release the core neurophysiological sources of physical or emotional pain, trauma, dissociation, and a variety of other symptoms. Left and right brain stimulation is enhanced with Biolateral sound delivered through earphones. In a typical session, the client focuses on the somatosensory experience of the symptom or problem, and a specific eye position is located (the "brainspot") that most activates the distress. The client fixes their gaze on that brainspot and this stimulates a deep integrating and healing process within the brain. This processing, which appears to take place at a reflexive or cellular level within the nervous system, brings about a de-conditioning of previously conditioned, maladaptive emotional and physiological responses. Brainspotting appears to stimulate, focus, and activate the body's inherent capacity to heal itself from trauma.

All of these methods can be directed at reducing distress but can also be utilized to establish and strengthen internal resources. For example, in EFT and BSFF, once negative affect and distress are reduced, positive affirmations can be installed. With BSP, clients can expand on existing positive resource states, or "pendulate" between resource states and trauma states to enable more gradual, graded processing and desensitization of intensely traumatic and emotionally charged issues and symptoms.

Mechanism of Action

Since Callahan's initial discovery, the mechanisms of EP have been further explored and defined. Feinstein (2018) explains that EP combines exposure therapy with interventions that reduce hyperarousal through acupressure and related techniques. This often leads to treatment outcomes that are faster and more powerful than techniques used in other exposure-based treatments such as relaxation or diaphragmatic breathing.

The underlying mechanism of action appears to be that tapping on those acupoints sends an electric signal to the amygdala, the emotional center of the brain that is associated with the fight-flight-freeze response and that also plays

a role in memory storage. Research at Harvard Medical School on the mechanisms of acupressure found that rubbing, tapping, or applying pressure to specific acupoints sends deactivating signals to the amygdala, setting off a cascade of biochemical reactions that allow the nervous system to shift into a more relaxed state, essentially moving from sympathetic nervous system arousal to parasympathetic relaxation (Fang et al., 2009; Hui et al., 2000).

Additional research has demonstrated significant changes in the brain and body resulting from acupoint stimulation, including normalization of brain-wave patterns (Lambrou et al., 2003; Swingle, 2010); changes in heart rate variability, heart coherence, resting heart rate, and blood pressure (Bach et al., 2019); decreased cortisol levels (Church et al., 2012); shifts of blood flow in the brain (Stapleton, 2019); and changes in gene expression associated with improved health and mental health (Church et al., 2018; Maharaj, 2016).

An additional component of the tapping treatment that appears to benefit psychological issues, particularly trauma, is memory reconsolidation. According to Feinstein (2018), after the amygdala receives the deactivating signal from tapping, it in turn signals the hippocampus, the part of the brain responsible for memory storage, to re-record the memory of the event or issue without the emotional distress—a phenomenon known as memory consolidation. This causes the neural pathways that initiated the stress response to be permanently altered, allowing the person to encounter the trigger without limbic arousal, essentially extinguishing the stress response (Schiller et al., 2010).

In terms of the safety of tapping, Church (2013, p. 650) reported that a review of clinical trials with over 1,000 participants found that no "adverse events" had been reported. Therapists using EP in treating survivors of childhood sexual abuse have indicated that their clients preferred this approach because it lessened the chances of being flooded with traumatic material and becoming re-traumatized (Schulz, 2009; White, 2015).

Research on EP

Over 250 review articles, research studies, and meta-analyses have been published in professional, peer-reviewed journals on the topic of EP (ACEP, n.d.).

EP tapping modalities, such as EFT and TFT, have been shown in a number of studies to be effective for mitigating the effects of PTSD and trauma, depression, anxiety, addiction, and other conditions often seen in mental health and addiction treatment (Feinstein, 2018; Sakai et al., 2001). Research on EP and addiction indicates that EFT has a beneficial effect on reducing cravings and emotional triggers to addictive behavior, such as anxiety and depression (Church & Brooks, 2010; Church & Brooks, 2013; Stapleton et al., 2020).

Stapleton has published a series of studies on food cravings in overweight and obese adults, demonstrating that EFT can effectively reduce food cravings, with fMRI imaging illustrating decreased activity in the limbic region, the parts of the brain believed to be involved in addictive behavior (Stapleton et al., 2019).

Much of the research on addiction and EP has been on food cravings, but EFT has also been successfully used to help individuals quit smoking by addressing such client concerns as cravings, withdrawal symptoms, relapse triggers, fears, discomfort, and more (Stapleton et al., 2013). Feinstein (2021) outlines a protocol for applying EP with substance use disorders according to the recognized stages of change. Specific targets of the protocol include: (a) relieving cravings and reprogramming maladaptive emotional or behavioral responses to triggers; (b) addressing unresolved emotional issues that were precursors to substance abuse; (c) instilling skills for better managing pain, stress, anxiety, and cravings; and (d) increasing self-esteem and confidence.

Several meta-analyses of EP treatments have been conducted on anxiety, depression, and PTSD, respectively. Of 14 randomized controlled trials (RCTs) examining acupoint tapping in the treatment of anxiety disorders, a large combined pre- to posttreatment effect size of 1.23 was indicated (Clond, 2016). For depression treated with tapping, another large effect size of 1.85 was found in a meta-analysis of 12 RCTs (Nelms & Castel, 2016). For PTSD, a very large effect size of 2.96 was reported in seven RCTs (Sebastian & Nelms, 2016).

When EP was compared to other evidence-based treatments such as CBT across a variety of mental health issues, eight studies found that the EP outcomes were equivalent or superior to the CBT outcomes, with results sustained over time (Feinstein, 2018). Feinstein highlights that results in a number of studies were obtained more quickly with EP methods than with CBT, requiring fewer

treatment sessions, which may indicate a cost-effectiveness benefit of these techniques.

In a comparison with EMDR, both approaches demonstrated large effect sizes in fewer than four sessions (Karatzias et al., 2011). This is of particular note, as the Brainspotting (BSP) technique used at Avery Lane derives from EMDR. It may be that the eye movement involved in EMDR and BSP functions similarly to the eye movements in the 9 Gamut sequence of EFT (D. Church, personal communication, January 29, 2021).

These emerging research findings suggest that EFT may be an effective and fast-acting adjunct to addiction treatment by reducing the severity of psychological distress, processing unresolved trauma, and reducing the cravings for substances.

Avery Lane Treatment Program

Avery Lane for Women is a private, eight-bed residential treatment facility in Novato, California, in the San Francisco Bay Area, offering 30 to 90-day residential treatment stays in addition to outpatient services for up to 12 women (averylanewomensrehab.com). Avery Lane serves women with co-occurring substance use and mental health disorders, particularly trauma. It offers four levels of care including detoxification, residential, partial hospitalization, and intensive outpatient treatment with the option of supportive housing in a sober living environment.

The program offers all the traditional gold-standard substance abuse treatments such as motivational interviewing (MI), MAT, CBT, dialectical behavioral therapy (DBT), relapse prevention, process groups, and 12-Step and other self-help groups, in addition to a variety of complementary alternative modalities including massage, Reiki, Access Bars, yoga, mindfulness, meditation, art therapy, nature therapy, and equine-assisted therapy. Trauma-specific curricula include *Seeking Safety* and *Beyond Trauma*, and clients also participate in classes such as Family Systems, Anger Management, Codependency, Medical Education, Life Skills, and Conscious Recovery.

Clients in residential treatment typically receive two individual therapy sessions per week, while outpatient clients receive one. Unlike other dual diagnosis programs, trauma processing is often started much earlier in treatment, in a safe, contained environment with 24/7 staff support. The program has also been designed to offer the unique possibility for the client to remain with the same therapist across all levels of care, which is not typically seen in other programs. This allows a strong therapeutic bond to form between client and therapist, and for the therapeutic work to deepen over a longer period of time. Many clients also choose to see their therapist in private practice after they complete treatment, another feature generally prohibited by other treatment centers.

Energy Psychology at Avery Lane

The EP techniques that this author (who is the clinical director at Avery Lane) has been using personally and in private practice since the year 2000 include EFT, TFT, BSFF, Tapas Acupressure Technique (TAT), Neuro Emotional Technique (NET), Reiki, Access Consciousness, and, though not officially recognized as an EP technique but seeming to function in a similar way, BSP. Several of these modalities have been brought into the treatment at Avery Lane. The EP modalities most frequently used are EFT, BSFF, and BSP.

When providing treatment to this population, third parties such as insurance companies and accrediting agencies generally require the use of evidence-based therapies. With its growing body of supportive clinical and research evidence, EP meets those criteria. According to ACEP (n.d.), methods such as EFT and TFT are both evidence-based and in the top 10% in terms of published research for psychotherapy modalities.

Applying the standards defined by the American Psychological Association's (APA) Division 12 Task Force on Empirically Validated Treatments, EFT has demonstrated efficacy for anxiety, depression, PTSD, and phobias (Feinstein, 2018). In 2016, TFT was validated by NREPP (the National Repository of Evidence Based Practices and Procedures, a division of SAMHSA) as an evidence-based treatment. EFT was under consideration with the same agency until the agency was defunded several years ago (ACEP, n.d.).

At Avery Lane, the EP tools are incorporated into group and individual therapy sessions. This author facilitates two EP groups per week, one for residential and one for outpatient clients. In the groups, clients learn the science behind tapping and how it works and engage in group tapping exercises on a variety of topics relevant to substance use and mental health treatment. They also

process personal issues at the group level with facilitation by the group leader.

All clinical staff are taught the EP methods in designated training sessions, and they often sit in on EP groups to learn and support the use of the tools in other groups and individual sessions. All therapists are trained in BSP techniques as well.

All the primary coping skills (including the EP tools) the clients learn are also taught to the front-line staff, that is, the residential counselors (RCs), which is not usually done at other treatment centers. The RCs are then able to support the clients in using the tools whenever they are activated, for example, on outings, when clients are troubled with symptoms, and during interpersonal conflicts brought on by communal living situations. Staff in EP training get the same handouts the clients receive and are encouraged to use the tools themselves to deal with their own issues, especially in the treatment setting when clients trigger countertransference. Tapping therefore benefits not only clients but also clinicians and program staff; they can learn to tap on themselves to reduce stress and increase their sense of peace and well-being. They then get to model for the clients how to handle difficult situations with healthier coping strategies using role-plays.

EP in Psychotherapy for Co-Occurring Disorders

In terms of psychotherapy, the Avery Lane program espouses a holistic and comprehensive approach to treating the physical, mental, emotional, and spiritual components of any issue, including addiction, anxiety, depression, PTSD, and trauma. EP techniques are an integral part of this approach.

The EP tools may be readily used in conjunction with other standard treatments to address the Four C's of addiction: craving, compulsion, loss of control, and continued use despite consequences (Amen & Smith, 2010). They can also enhance the ability of motivational interviewing (Miller & Rollnick, 2013) to explore and shift clients' ambivalence about change, to explore and clear their limiting beliefs about being able to change, and to address their fears, doubts, and worries about what will happen and what people will think of them if they do change.

Other applications of BSP or the EP tools for addiction include using EFT or BSFF to help clients reduce cravings to drink and use drugs; to mitigate physical pain that triggers cravings; to diminish feelings of anxiety, sadness, shame, or resentments that are triggers to use; to reframe and clear limiting thoughts and beliefs, such as "I'm not enough" or "I'm a bad person," that underlie addictive behaviors; and to minimize feelings of emptiness or disconnection from self/others/Higher Power.

Therapists vary in their levels of expertise with the various techniques, and some favor certain approaches over others. Clients also tend to align with some tools more readily than others, and therapists respect their wishes. This author uses clinical intuition and client preference when choosing which technique to utilize in a given session.

EP can also be combined with other standardized treatments such as CBT. In the EP group, we do a CBT thought record then use EP techniques such as tapping or BSFF to further release any remaining emotional distress. The tools can also be used to treat psychological reversals, a concept originating from Callahan (1995), which addresses self-sabotage in the form of subconscious beliefs (e.g., secondary gains a client gets from keeping the problem, or concepts like "It's not safe for me to let this go," "I don't deserve to be free of this," or "I don't like who I'd be if I changed this."). EP can also be used to install positive cognitions such as affirmations.

In trauma-specific groups such as *Seeking Safety* or *Beyond Trauma*, when clients get triggered by the material being discussed, they can stop and tap to reduce their level of distress. Tapping is also used to help clients who are dissociated get grounded and back into their bodies.

Clinical application of these tools at Avery Lane has shown that when clients can reduce the emotional distress that triggers their substance use, they can effectively curtail their addictive behaviors, including releasing the idea that the alcohol or drug will make them feel better, reminding themselves they have other choices, and engaging in positive self-talk and affirmations. The tools are therefore taught to the clients to use as coping skills for emotional self-regulation.

The EP techniques are also utilized in therapy to treat the underlying roots of presenting issues, which are often unresolved trauma or upset from the past that keeps getting retriggered in the present. They can be considered a form of somatic

therapy that allows the body to release rapidly and effectively the stuck energies from trauma. The tools also assist clients in getting out of the hyperarousal of the nervous system associated with PTSD and the fight-flight-freeze response.

The benefit of using these nervous system calming techniques is that they allow a person's reasoning capacities and higher-order processing to come back online quickly to make safer and wiser choices than the dangerous or self-harming behaviors that had been used when the client was under duress. Clients can't think straight when they are intensely triggered and in a state of fight-flight-freeze, which is why many strategies like CBT do not seem to be very effective in those moments.

Materials and Methods

Avery Lane has retained the services of Vista Research Group (www.vista-research-group.com) to implement a variety of computer-administered client self-report measures at intake, discharge, and weekly throughout treatment. The standardized instruments utilized include the Patient Health Questionnaire depression module (PHQ-9; Kroenke et al. 2001), Generalized Anxiety Disorder–7 scale (GAD-7; Spitzer et al., 2006), PTSD Checklist-6 (PCL-6; Lang et al., 2012), Columbia–Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011), and Eating Disorder Diagnostic Scale (EDDS; Stice et al., 2000), along with a number of nonstandardized questionnaires, including one to assess frequency of cravings to drink or use. Clients are asked to complete voluntarily the measures to assess their progress during treatment.

Demographics and Intake Statistics

Table 1 details the demographics of the 147 clients for whom data were collected in the period of November 2, 2017 to February 9, 2021.

With regard to primary drug of choice, 64% of clients in the data group reported their preferred substance as alcohol, 8% methamphetamines, 7% opiates, 3% cannabis, 3% benzodiazepines, 3% heroin, 3% amphetamines, 2% cocaine, 1% inhalants, and 6% other.

Addiction level was identified as severe for 52% of clients (meeting every criteria established by the DSM-5), moderately severe (endorsing 6-10 DSM-5 criteria) for 40%, moderate for 3%, and mild for 3%, with only 1% of clients reporting no substance use disorder.

Thirty-nine percent of clients reported this was their first substance treatment episode, 9% had one prior treatment experience, 26% had two to three episodes, 18% between four and six episodes, 6% had seven to nine episodes, and 1% reported 10 or more prior treatment episodes.

Table 1. *Client Demographics*

Age		Age range: 18–73
		Median age: 39
Ethnicity	86%	Caucasian, non-Hispanic
	3%	Hispanic/Latina
	3%	Asian
	1%	African-American
	8%	Other
Marital status	42%	Single/never married
	33%	Married
	15%	Divorced
	8%	Separated
	1%	Widowed
Highest education attained	1%	Doctorate degree
	7%	Master's degree
	35%	Bachelor's degree
	12%	Associate's degree
	26%	Some college
	9%	High school/GED
	1%	Did not graduate high school
	9%	Other
Employment	25%	Employed full-time
	11%	Employed part-time
	9%	Working in the home
	4%	Going to school
	2%	Working and going to school
	26%	Not working or going to school by choice
	6%	Not working or going to school due to being fired or kicked out
	16%	Other
Living situation	62%	Stable, living in own home or dorm room
	14%	Stable, living in family's home
	6%	Stable, other
	4%	Stable, living in a sober living environment
	8%	Unstable, other
	6%	Unstable, moving from place to place
	1%	Homeless

Regarding mental health symptoms, at the time of intake, 88% of 140 clients reported depressive symptoms (40% rating their depression as severe, 27% moderately severe, 11% moderate, 10% mild), 93% cited anxiety symptoms (50% severe, 24% moderate, 19% mild), and 83% reported trauma symptoms (69% severe PTSD, 6% probable PTSD, 2% possible PTSD, 6% mild PTSD).

With regard to suicidality, 53% of clients reported that they wished they were dead or would go to sleep and not wake up; 35% admitted to suicidal thoughts; 24% had thought about how they would kill themselves; 14% intended to act on those thoughts; 10% started working out the details; 10% intended to carry out the plan; and 10% had recently prepared, started, or attempted suicide.

Eating disordered behaviors included 35% of clients reporting binge eating (distressful nighttime eating and eating large amounts of food and losing control) and 45% reporting compensatory behaviors (fasting, vomiting, intense exercise to counteract eating, laxative/diuretic use), with 4% reporting low body mass index/possible anorexia.

Overall, the population treated is a group of severely impaired, dually diagnosed women, the majority of whom have had previous courses of treatment, and who are dealing with a number of serious mental health and substance use disorders, especially depression, anxiety, trauma, suicidality, eating disordered behaviors, and PTSD.

Results

The median length of stay for all clients was 63 days (*n* = 119), 33 days for those in detox/residential levels of care (*n* = 63), and 101 days for those attending partial hospitalization/intensive outpatient levels of care (*n* = 56).

Seventy-seven percent of all clients successfully completed treatment (*n* = 130), 8% left early against medical advice, 8% were terminated for administrative reasons, 5% were transferred to another treatment program, and 2% were discharged for other reasons. When compared to other private treatment programs that employ the services of Vista Research Group (*n* = 37,443), Avery Lane achieved similar but slightly better outcomes; the data for the other programs included an average of 73% of clients who successfully completed treatment, 11% left early against medical advice, 5% were terminated for administrative reasons, 4% were transferred to another treatment program, and 5% were discharged for other reasons (M. O'Sullivan, personal communication, April 29, 2021).

When compared to national statistics, Avery Lane's outcomes are significantly better than norms provided in the 2017 Treatment Episode Data Set–Discharges (TEDS-D; SAMHSA, 2019), which cite a low 41% successful completion rate, with 30% dropping out of treatment, and 22% transferred to further treatment. Note that the TEDS data set consists primarily of publicly funded treatment programs receiving funding from the federal and/or state governments. Avery Lane is a private corporation that receives revenue from insurance and private pay.

Progress in treatment, as measured by comparing the self-report measures at intake and discharge (or last survey prior to discharge), indicate that a significant improvement in mental health symptoms occurred for the majority of clients (*n* = 116–123). Depression scores on the PHQ-9 dropped from an average of 79% at intake to 16% at last survey, $p < .001$ (Figure 1). Anxiety scores on the GAD-7 fell from 73% to 8%, $p < .001$ (Figure 2). PCL-6 scores for trauma symptoms went down from 76% to 30%, below the probable PTSD threshold, $p < .001$ (Figure 3). Suicidality levels measured by the C-SSRS fell from a high of 53% of clients at intake wishing they were

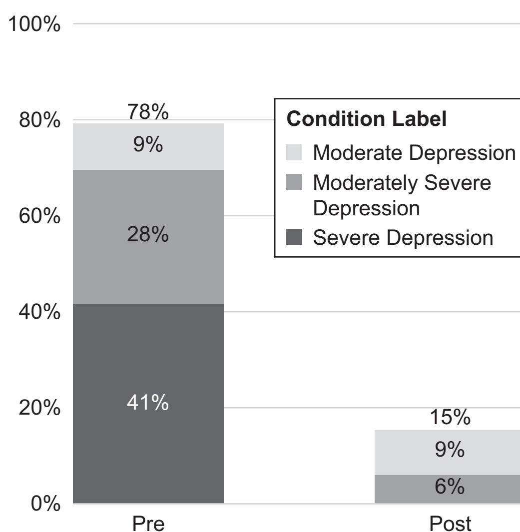

Figure 1. Patient progress on progression symptoms (PHQ-9), *n* = 116.

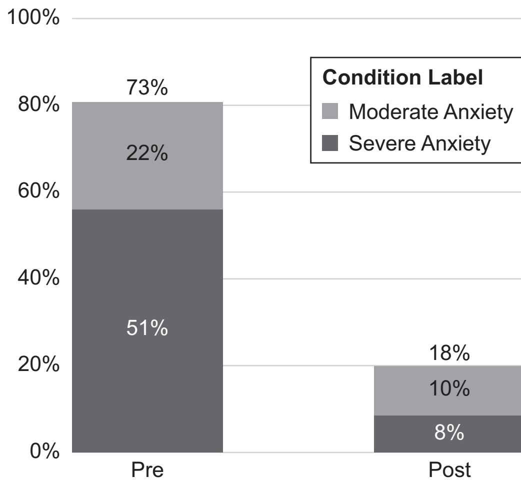

Figure 2. Patient progress on anxiety symptoms (GAD-7), $n = 116$.

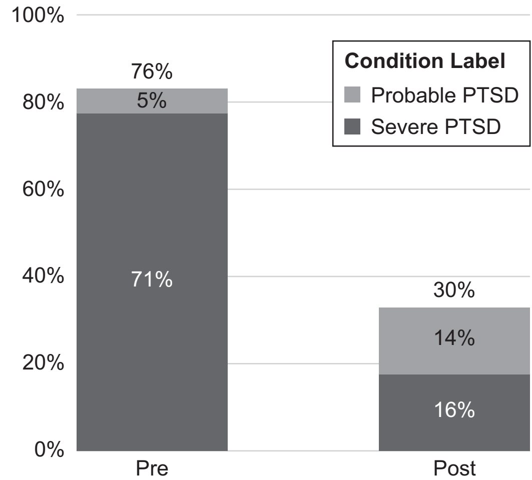

Figure 3. Patient progress on trauma symptoms (PCL-6), $n = 116$.

dead to 11% at last survey, $p < .001$, with similar reductions in other suicidal behaviors (Figure 4). For the EDDS, eating disordered behaviors showed binge eating rates dropping from 33% to 11%, $p = .01$, and compensatory behaviors with a drop from 41% to 11%, $p = .074$ (Figure 5).

Client Feedback

Overall, 82% of clients who came to Avery Lane reported being "very satisfied" with their treatment; 12% were "somewhat satisfied," 3% were "neutral," and 3% were "somewhat" or "very unsatisfied" (see Figure 6).

With regard to the use of EP methods, at first some clients were skeptical and judged the techniques to be strange. They reported, however, that it was highly beneficial to learn about the science behind EP approaches like EFT. Then when they tried it in groups or individual sessions and experienced stress relief in minutes (faster than a drink or pill), they were usually convinced. Clients were drinking and using primarily to quell

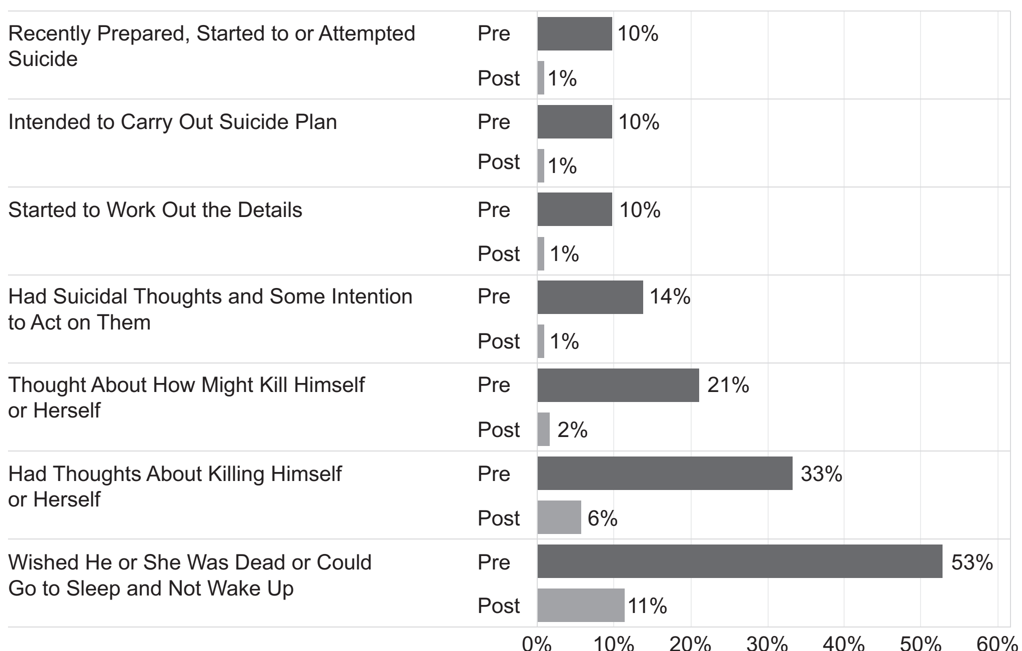

Figure 4. Patient progress on suicidal thoughts and intention, $n = 123$.

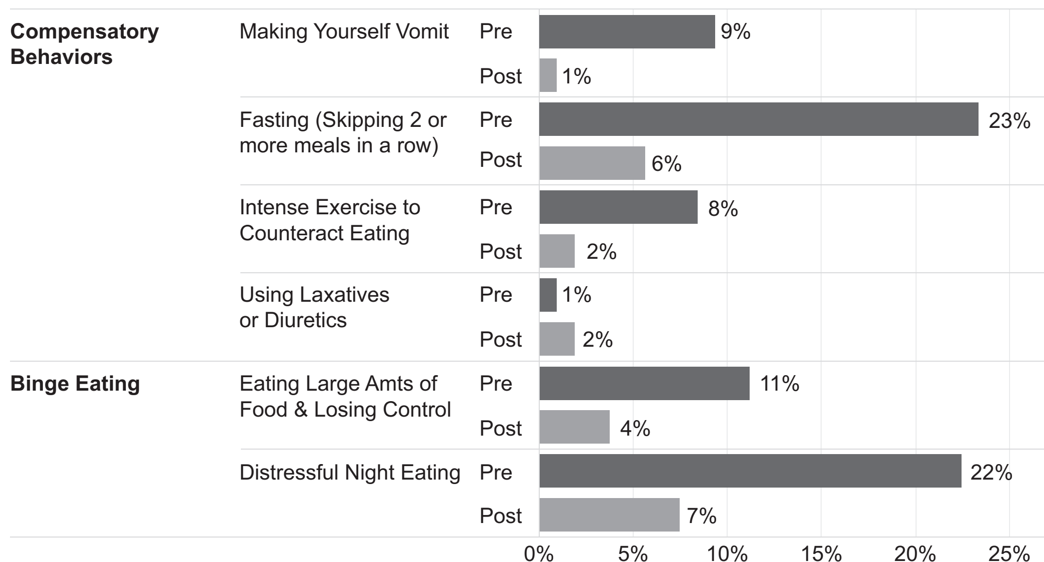

Figure 5. Percent of patients exhibiting eating disorder symptoms (EDDS), *n* = 107.

feelings of depression, anxiety, low self-esteem, shame, and anger, or to deal with symptoms of trauma and PTSD. When they discovered that they could use these tools to change the way they feel in a healthier way, they were empowered and their self-esteem and self-efficacy began to increase.

This strategy appears to be generating dramatic results. Clients are making significant changes in healing their traumas, limiting beliefs, and low self-esteem, and improving their relationships and interpersonal communication. Staff are grateful for the tools and feeling empowered to help the clients without going into compassion fatigue and codependency.

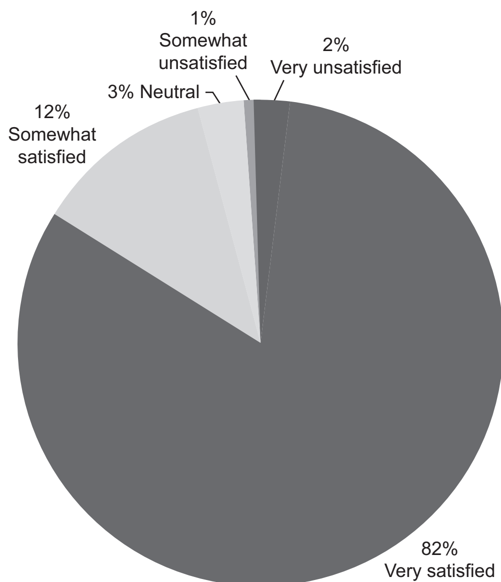

Figure 6. Patient satisfaction with treatment, *n* = 518.

Some specific quotes culled from client satisfaction surveys include:

"I feel like I'm learning a lot toward rewiring the way my brain thinks about myself and addiction and learning tools to deal with anxiety."

"Local, small, female-centered, alternative coping skill modalities, thorough exit plan—best care I have received in a treatment environment."

"Am learning sooo much. Also I love the variety of the treatment. Different teachers, different methods. This is good for me because I don't believe any one thing is going to help me, it's going to be a combination."

"I'm so grateful I got to come here…Clearing old unprocessed trauma energy is critical to my sobriety, and it's been done in a very organized manner here. Yay!"

"[My therapist] is amazing and the Brainspotting works wonders! I felt very comfortable and safe with her and she helped me through difficult traumas and memories that led me to use drugs until I came into recovery. She worked with me by being gentle and kind. I hope I can continue (and afford) to work with her after I leave Avery Lane because I admire her and the work she is doing with brain therapy. I find it fascinating even though I have to put the work into the sessions I always feel a level of self-empowerment and worthiness which I wasn't sure I was capable of feeling."

"The holistic approach with intensive trauma work has been incredibly effective…my therapist seems to intuitively understand. I've never felt so safe, loved, and understood in my life. I've found peace. Currently they are working on helping me maintain that sense of peace for longer stretches at a time… I have hope again."

Therapist Feedback

Here is what a few of the therapists at Avery Lane (who previously had little to no experience with EP tools) have said about using these techniques:

Therapist #1. "When first introduced to EP, I began using the tools on myself. I was amazed at how quickly I felt a positive shift in thoughts, sensations, and feelings. Each time I used the tools, I had the same positive results. It was as if a reset button had been pushed which allowed me to be more present and focused. I began offering the tools to my clients and each reported similar experiences and I noticed they continued to use the tools autonomously between sessions. The tools were especially effective in clients with trauma by decreasing stress, anxiety and increasing emotion regulation, giving clients a sense of empowerment and safety.

"Clients in treatment have experienced similar results and have the added benefit of learning and using these tools as a group and witnessing a reduction of symptoms in each other. Because these tools activate mind and body processes simultaneously, clients are better able to make use of their limited time in treatment for real change and healing."

Therapist #2. "The biggest notice with EP tools for clients and myself is the instant reduction in anxiety in the moment (short-term gain). Secondary long-term gain seems to be the increase in self-confidence and/or self-esteem that contributes to their belief they can stay sober because they have tools to self-regulate."

Therapist #3. "As for my experience as a therapist, I can say that EP enhances my ability to empower clients to directly experience, internalize, and regenerate the kinds of shifts that bring deep and lasting change. Beliefs, in my experience as a therapist, are not readily moved. Staying on the level of simple 'talk therapy' is relatively limiting when I can, conversely, incorporate energetic neurobiological regulation techniques to facilitate a client experiencing a more whole-being consciousness of what is possible. Then, with that felt experience, with that belief in the practicality of these tools, clients are able to continue developing on their own, as empowered and creative beings, rather than feeling quite so dependent on a therapist for scaffolding psychological flexibility. Anecdotally, I consistently see far greater/deeper evolution in my clients between sessions when they use EP tools, as compared to those who do not. No question."

Case Studies

Here are a couple of examples of specific clients treated with these EP techniques.

Client #1. This client is a 36-year-old female with mental health diagnoses of severe major depressive disorder, PTSD, and generalized anxiety disorder, with polysubstance use including opioid (IV heroin and Oxycontin), alcohol, and cannabis use disorders. Prior to treatment, she had not worked for over two years as a health care professional, was isolated in her home alone, malnourished, and not functioning. She reported a long history of physical and emotional abuse from family members throughout her life and cited symptoms of severe depression, passive suicidal ideation, low motivation, and feelings of hopelessness at intake, along with PTSD symptoms of flashbacks, hypervigilance, intrusive thoughts, exaggerated blame of self for causing the trauma, emotional distress, high levels of anxiety and psychomotor agitation, and difficulty experiencing positive affect.

Client #1 participated in our detox/residential program for 52 days, partial hospitalization program (PHP) for 40 days, and intensive outpatient program (IOP) for 45 days. In that time, she attended a total of 221 treatment groups, including 21 EP groups. She received 15 individual therapy sessions focused on treatment goals, case management, aftercare planning, family dynamics, and more, and 21 individual therapy sessions with this author utilizing techniques such as BSP and EFT. These sessions were focused on trauma processing (including her family abuse and the unexpected death of her Avery Lane therapist while in treatment), negative self-cognitions, high levels of shame and guilt, and extremely low self-esteem. The client also diligently practiced the EP and other tools she learned in treatment and applied them to her life on a daily basis.

This client made significant progress in treatment. At the time of her successful discharge from outpatient treatment, she was stable on MAT and had seven months sober, was able to quit smoking tobacco, built a sober support system, and learned to set healthier boundaries with abusive family members. She realized that her primary abuser was a malignant narcissist and she was able to release feelings of self-blame and shame that she had deserved the abuse.

With regard to her mental health, she reported a remission of depressive symptoms and suicidal ideation, and a significant reduction of anxiety and PTSD symptoms. She began to access positive emotions, engaging in pleasurable activities and experiencing spiritual reconnection and growth. She reported having a sense for the first time of seeing herself in old age; she had previously felt that she would commit suicide before then. Her motivation level increased and she took steps toward preparing to go back to work.

On her Vista self-report surveys, her depression scores fell from 16/27 (moderately severe depression) to 4/27 (no depression), anxiety decreased from 12/21 (moderate anxiety) to 2/21 (minimal anxiety), trauma symptoms reduced from 21/30 (severe) to 7/30 (low), suicidal thoughts fell from 3/7 to 0/7 (no suicidal thoughts), eating disordered behavior (restricting) dropped from four times a week to 0, and frequency and severity of cravings for drugs and alcohol decreased from moderate to mild.

Client #2. This client is a 33-year-old woman with PTSD, major depressive disorder, alcohol use disorder, and significant binge use history of opioids and cocaine. The client had previously completed 26 days of residential treatment at another program, maintained eight months of sobriety, and was enrolled in an IOP program when she relapsed. Triggered by grief over the recent death of a grandparent who had raised her, she relapsed on a binge of alcohol, opioids, and cocaine and was found passed out on a bathroom floor. She sought treatment due to awareness of need and willingness finally to address her unresolved trauma and grief.

This client reported an extensive history of trauma, especially in childhood. She grew up with addicted parents and was physically, emotionally, and sexually abused. She was removed from home at age 7 to live with her grandparents, and the family member who sexually abused her went to prison. Since that time, she experienced PTSD symptoms of intrusive memories and flashbacks, frequent nightmares, and hypervigilance, which led her to use substances to access a sense of relief from chronic and exhausting anxiety and shame. While she took on perfectionistic traits, including workaholism, to distract from worry and shame, she would feel compelled to become intoxicated when she was not otherwise occupied.

She reported that she felt such shame about her history of abuse that she struggled to connect with others, unable to allow herself to be vulnerable enough for others to get to know her or support her in an intimate way, leading to social isolation. She also exhibited poor boundaries, with codependent tendencies and a history of intimate partner violence as an adult.

After the death of her grandparent, the client's shame and emotional isolation increased and depression ensued, marked by anhedonia, reduced social activity, and severely restricted eating. She also exhibited symptoms of severe anxiety, unable to make eye contact or speak in groups when she first arrived to treatment.

The client participated in 32 days of detox/residential treatment, followed by 15 days of PHP sessions. She attended a total of 78 treatment groups, including eight EP groups. She received 11 individual therapy sessions, which included one BSP and two EFT tapping-focused sessions for grief and trauma processing.

She responded positively to the scientific explanation of EFT and began to use it to regulate her anxiety, which led her to experience empowerment over her automatic thoughts and core negative beliefs. She was able to use tapping to process through her guilt and move into a more empowered energy. Within one to two weeks, she also exhibited a remarkable shift in her willingness to share with vulnerability; she was able to speak openly about her abuse history and transformed her feelings of shame. She also used tapping to work through codependent and perfectionist tendencies getting in the way of creating and holding healthy boundaries. This resulted in an increase in self-care and self-respect, including building supportive relationships and a reduction in workaholic behavior.

With regard to her grief, Client #2 reported a shift to a perspective of gratitude for those she had lost and a renewed connection to them, even in her dreams. She also reported feeling a sense of

hope that she could enjoy her life moving forward, which had been altogether absent for quite some time. She identified as having a spiritual awakening in treatment, and stated "Avery Lane has opened so many doors for me about recovery that I never knew about before."

Overall, the client experienced a remission in symptoms of depression and PTSD intrusion (nightmares, hypervigilance, and flashbacks) and, with her new tools, was able to cope with infrequent situational anxiety. Her reported isolative behavior improved and she increased healthy recreation and social interaction. At discharge, she reported feeling at peace with a knowing that she deserves to feel hope and joy, and does not need to accept suffering as she used to believe.

Client #2's excellent progress in a relatively short period of time is corroborated by her Vista survey results. Her self-reported depression scores fell from 23/27 (severe depression) to 0/27 (no depression), anxiety reduced from 12/21 (moderate anxiety) to 0/21 (none), symptoms of trauma went from 19/30 (severe) to 6/30 (minimal), eating disordered behavior (restricting) dropped from seven plus times per week to 0, and cravings for drugs and alcohol stayed consistent at almost none.

Conclusion

In working for over 20 years in the addiction treatment field, both as a clinician and as an administrator, this author has witnessed time and again that the majority of clients who present for substance abuse treatment suffer with co-occurring disorders, an observation that is backed by research (NIDA, 2020). They typically lack coping skills to manage effectively their negative thoughts and emotions, which are the primary triggers for their substance use. If their mental health symptoms are not addressed and well managed, clients will rarely be able to sustain long-term abstinence.

Furthermore, unresolved trauma is present in the vast majority of clinical cases. Symptoms such as hypervigilance come from an overactive nervous system that leaves clients in a constant state of fight-flight-freeze. This is a primary reason why many clients are self-medicating with drugs and alcohol. If they don't learn how to rewire and re-regulate that trauma response, they won't stay sober. Research cited in this paper supports these observations.

Research and clinical practice suggest there is a need for effective, holistic, comprehensive approaches that address the physical, mental, emotional, and spiritual components of these conditions. EP offers that, providing clients with empowering tools for emotional self-regulation and deeper trauma processing on all levels. EP techniques are often exceedingly rapid, have little to no adverse effects, and are usually experienced as self-empowering by therapists and clients alike.

Some of the benefits of EP reported in the literature and corroborated by the work at Avery Lane include: (a) a reduction and elimination of the effects of trauma more quickly and effectively than traditional talk therapy and other evidence-based approaches, (b) increased access to insight and positive cognitions that were obscured by trauma, and (c) an increase in a sense of self-control and confidence in knowing they can regulate their emotions on their own without the aid of drugs and alcohol (Feinstein, 2018).

The population at Avery Lane is a group of severely impaired, dually diagnosed women, the majority of whom have had previous courses of treatment, and who are dealing with a number of serious mental health and substance use disorders, especially depression, anxiety, trauma, suicidality, eating disordered behaviors, and PTSD. While at first some clients may have been skeptical about EP, once they learned about the science and research supporting it and they tried it for themselves, they became more open to applying the tools to a variety of areas, including cravings, mental health symptoms, core limiting beliefs, and motivation to change. When they discovered that they could use these coping tools to change the way they feel in a healthier way, they were empowered and their self-esteem and self-efficacy began to increase, leading to improved relationships, interpersonal communication, and overall quality of life.

Specific results obtained at Avery Lane for this study include statistically significant reductions in self-reported levels of depression, anxiety, PTSD, and suicidality, with $p < .001$ for most measures (except the eating disordered behaviors), particularly compensatory behaviors. The results for eating disorders (ED) may be because they are not generally a focus of treatment at Avery Lane, staff are not specialists in this area, and clients with more severe ED behaviors are typically referred out to ED specialty programs.

The Avery Lane data support results from other studies on addictive behaviors including food cravings (Stapleton et al., 2019) and smoking cessation (Stapleton et al., 2013). Given that persons with addictive behaviors are often attempting to "self-medicate" emotional distress and mental health symptoms with substances, our results further corroborate the work of Church and Brooks (2010, 2013) and Stapleton et al. (2020), which suggest that reducing the intensity of anxiety, depression, and PTSD symptomology has a beneficial effect on reduction in substance use. Similar to the Reset program at Fort Hood (Libretto et al., 2015), it appears that Avery Lane's integrated approach to PTSD treatment, which includes traditional psychotherapeutic techniques, EP, and CAM, is highly effective in reducing symptoms of depression, anxiety, PTSD, and more.

Limitations of this study include a relatively small and less demographically diverse sample group (n = 123), lack of control or other comparison groups, and an inability to differentiate which techniques may have been most effective in achieving the strong results obtained. Longer follow-up to see if results are maintained over time would have also been useful, and to this end, Avery Lane has recently employed Vista Research Group to begin collecting these data.

As science continues to learn more about how the brain functions through brain imaging and the study of epigenetics, the mechanisms underlying EP techniques and how these techniques can positively affect the brains of dually diagnosed individuals who have been struggling with addiction and mental health disorders will become clearer. Further studies are needed to validate EP techniques for this population and to assess their potential as a viable cost-effective approach that can shorten the length of treatment.

Recommended treatment guidelines for facilities wishing to add EP to their current treatment approach include the following: Hire one or more therapists who are already well versed and skilled in EP. Have those clinicians demonstrate the techniques to other staff (including frontline staff), use client role-plays, and have staff practice on one another with their own personal issues and issues of transference/countertransference that arise when working with clients. If the EP tools are taught in therapy groups, have other staff attend as well so they can observe how the experienced practitioner teaches the skills and utilizes them with specific client issues. Supplement group and individual sessions with YouTube videos and other resources such as videos, audios, and handouts from the annual Tapping World Summit (thetappingsolution.com), ACEP's Resources for Resilience (www.r4r.support), and EFT Universe (eftuniverse.com), among others. Be sure the trained EP practitioner is available for case consultation on an ongoing basis and that refreshers or additional trainings are offered periodically to grow and reinforce skills.

This author has found that staff buy-in is very important, especially when trying to introduce clients to these nontraditional treatment methods. It may take some time to convince clinicians and counselors (especially those entrenched in their own preferred approaches) that these sometimes strange-appearing techniques are effective. Explaining the research and science behind EP can be very beneficial in this regard. Inviting staff to experiment with the tools for their own issues and observing the positive results the clients get with them is key to shifting their perspective. As a majority of staff become open and supportive of the tools, others will often get on board as well. At Avery Lane, staff have expressed gratitude for the EP tools and feel more empowered to help the clients without going into compassion fatigue, vicarious traumatization, and codependency. This has ultimately improved staff morale and employee retention.

In the four years since its inception, Avery Lane has successfully integrated EP as standard of practice in our treatment program, and it is our hope that other programs will be inspired by our experience to try these approaches for themselves. As one therapist's thesis on EP for treating trauma stated: "Energy psychology has the potential to catalyze a process of transformation that results in a lived experience of serenity and flourishing" (White, 2015, p. 2). Many of our clients and staff have experienced these powerful results thanks to EP.

The data and clinical results from Avery Lane are consistent with those derived from meta-analyses, clinical trials, and experiences at other treatment centers. This body of literature demonstrates that EP is a powerful, evidence-based approach that sets the standard for effective addiction treatment.

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